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ABSTRACT

The purpose of this book is to help children in grades 2-6 realize that being "different" is okay; in fact, it makes people more interesting and makes the world a better place. The book is intended to help children with disabilities feel better about themselves, and to help children without disabilities see that people who have disabilities have different ways of accomplishing daily tasks but can do almost anything in their own way. The colorful illustrations enhance the text, which begins with explanations that people live in different kinds of houses, drive different kinds of vehicles, wear different clothes, and have different kinds of bodies, and they are all of value, though sometimes they don't fit or work when they are in the wrong place/space. Differences in people's bodies mean that they must do things differently, and may require special help, but the differences are not bad and each person is of value. The nuisance of not being able to read, concentrate, or speak clearly can make people feel depressed or angry, or they can make people feel more determined to succeed. Famous individuals from history who had disabilities are cited. (JDD)

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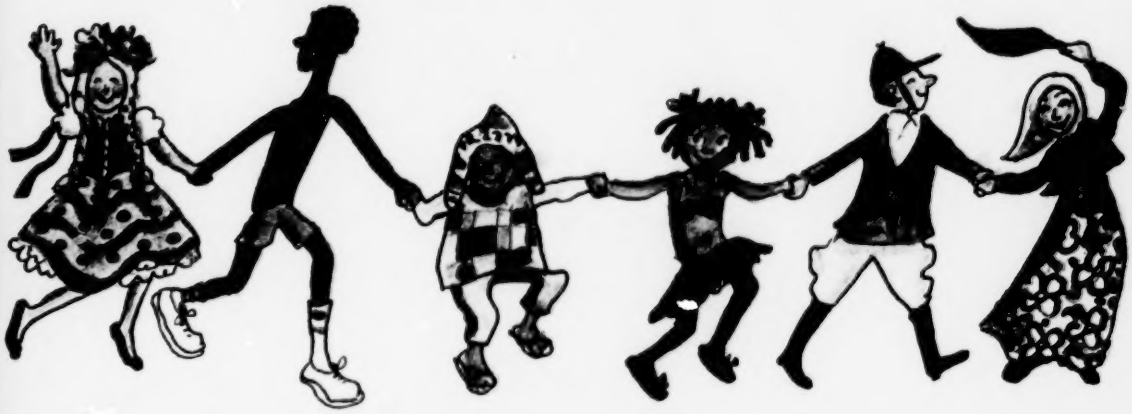
Dedication

For Randy
my lawyer, my friend, my firstborn son
with love

Different is NOT BAD

Different is the WORLD



A Book About Disabilities

by Sally L. Smith
illustrated by Ben Booz

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About the Author

Sally L. Smith founded The Lab School of Washington in 1967 to provide an education for her bright, but severely learning disabled, son. Since then she has gained a reputation as a leading force in the field of learning disabilities, and the effectiveness of her innovative teaching methods has earned her international recognition. The Lab School has since grown to provide a variety of education, testing, tutoring, and support services for adults as well as children.

As professor in charge of The American University Graduate Program in Special Education: Learning Disabilities, Professor Smith has also trained thousands of teachers.

With an intimate sensitivity, Professor Smith understands the frustrations and challenges faced by both parents and teachers of children with learning disabilities. Her books *No Easy Answers: The Learning Disabled Child at Home and at School* and *Succeeding Against the Odds: How the Learning Disabled Can Realize Their Promise* have brought inspiration, guidance, and practical advice to thousands.

A tireless advocate for the learning disabled, she has authored many articles and frequently speaks to parent, teacher, and educational organizations.

In 1993, Professor Smith received the LDA Award, the highest honor given by the Learning Disabilities Association of America for outstanding leadership in the field of learning disabilities.

About the Illustrator

Ben (Elisabeth) Booz is an artist, painter, illustrator, teacher, and editor. She has illustrated and written two children's books and one young adult novel. She illustrated Sally Smith's book *No Easy Answers: Teaching the Learning Disabled Child* (Winthrop Publishers, 1979). Recently, she has illustrated numerous articles in the travel section of *The Washington Post*.

Ben Booz and Sally Smith have collaborated on many projects since 1967 when Ben taught The Cave Club at The Lab School. A teacher for many years at the Sandy Spring Friends School in Maryland, she was the first American woman to teach in Kunming, China after the Revolution of 1949.

Introduction

The purpose of this book is to help children (grades 2-6) realize that being "different" is O.K.; in fact, it makes people more interesting and the world a better place. This book is intended to help children with disabilities feel better about themselves. Plus, children without disabilities will see that people who are different have different ways of accomplishing everyday tasks, but people can do almost anything in their own way. The message is: Respect and prize diversity!

For Teachers, Parents, and Other Adults

When reading this book to children, have them discuss each set of drawings, then point out that each set is very different, all good, each of value (each important).

When seeing that something may not work, when it is in the wrong place, or doesn't fit, elicit from the children, "Why not?" Pages 7 and 11 talk about "a nuisance," which can be interpreted to be "a bother," "an obstacle," or "a pain."

On pages 14-17, when discussing what each person does well, help the children reflect on what one or two things they do best and what activities cause them difficulties.

Pages 21 and 28 discuss people's patchwork quilts of abilities and nuisances. Talk frankly about your own strengths and weaknesses with the children. For example, "I read and write well, but I've never been good at sports or math." Then ask the children to discuss theirs.

After reading the whole book, demonstrate visually to the children how you might fill in on paper a patchwork quilt of your "CAN DOs" and "CAN'T DOs." Then have them color and label (or dictate, if they can't read or write) their own unique quilts.

You will need to read this book to the children several times and help them to look at all the pictures very carefully. Children may then be given the book to read on their own if they are able, or to use the audio tape (available from the publisher) to listen to the book being read. It is hoped that with the audio tape they will point to each of the drawings, look at them in detail (time has been provided on the tape before each "page turn indicator" for the children to examine the pictures), talk about them, and reflect on the fact that differences are O.K.

The world has many different countries,

each with its own holidays.

VERY DIFFERENT,

ALL GOOD,

each of VALUE.

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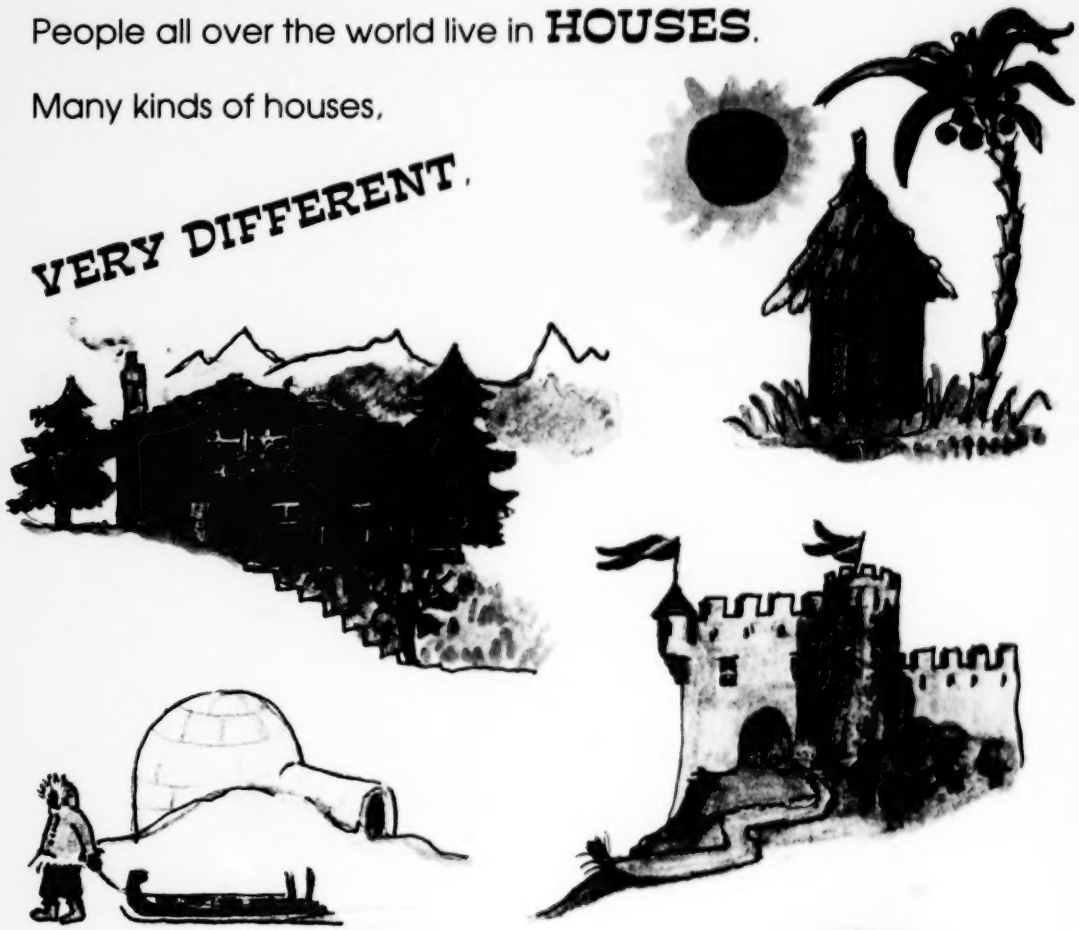
People all over the world live in **HOUSES**.

Many kinds of houses,

VERY DIFFERENT,



each of VALUE.

They are

ALL

GOOD

even though

some of them may not work

when they are in the **WRONG PLACE**.

People all over the world like to **DRIVE**

many kinds of vehicles,

VERY DIFFERENT,

each of VALUE!

They are

ALL GOOD.

But sometimes they don't work

when they are in the **WRONG PLACE.**

All over the world, people wear **CLOTHES**.

They are all **VERY DIFFERENT**,

but each of **VALUE**.

They are

ALL GOOD.

But sometimes they are a **NUISANCE.**

They don't **FIT,**

they are in the **WRONG PLACE.**

Everybody in the world has a **FACE**
and every face is **DIFFERENT**.

THEY ARE ALL GOOD.

Yours is, too!

Faces show **FEELINGS**.

FEELINGS

are all

O.K.

But sometimes they are expressed at the

WRONG TIME, in the **WRONG PLACE**.

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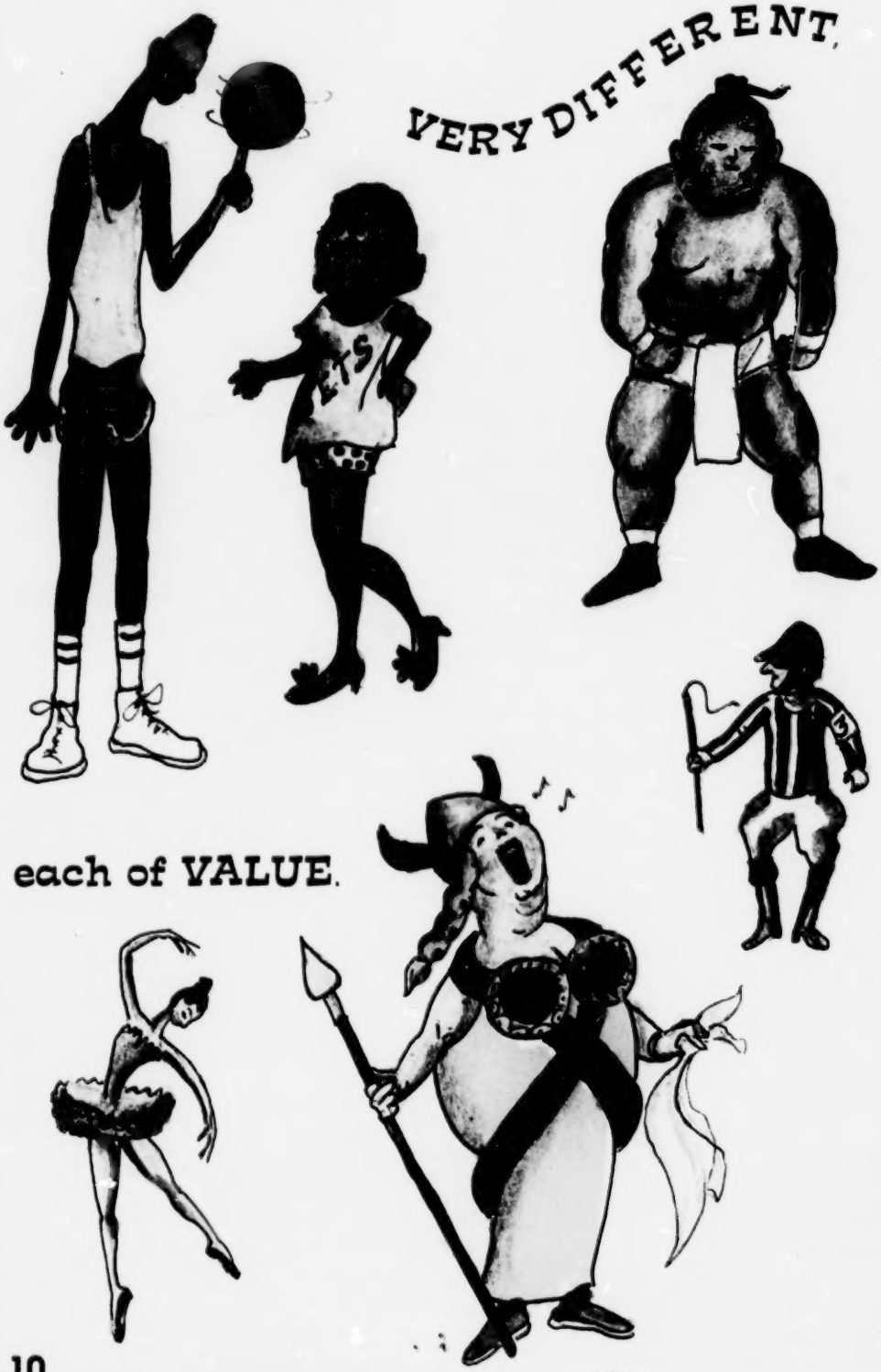
People everywhere have different kinds of BODIES,



each of VALUE.

They are

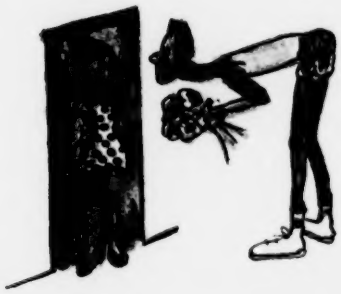
ALL GOOD.

But sometimes they are a

NUISANCE

when they don't **FIT**,

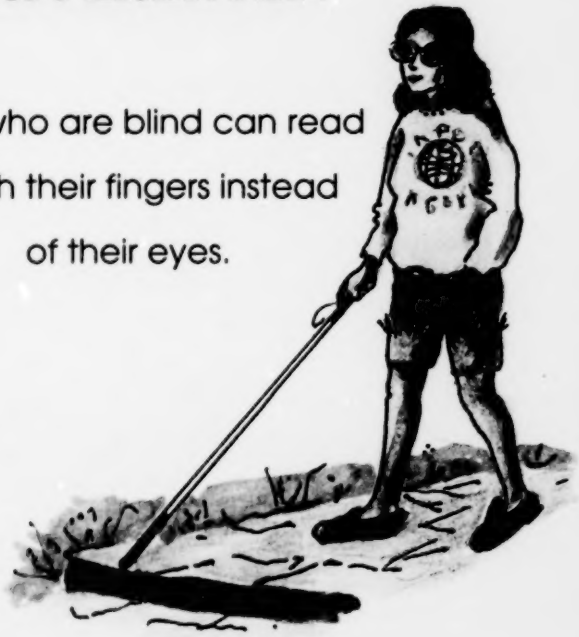
when they are in the **WRONG SPACE**.



Sometimes differences in our bodies mean that we must

DO THINGS DIFFERENTLY.

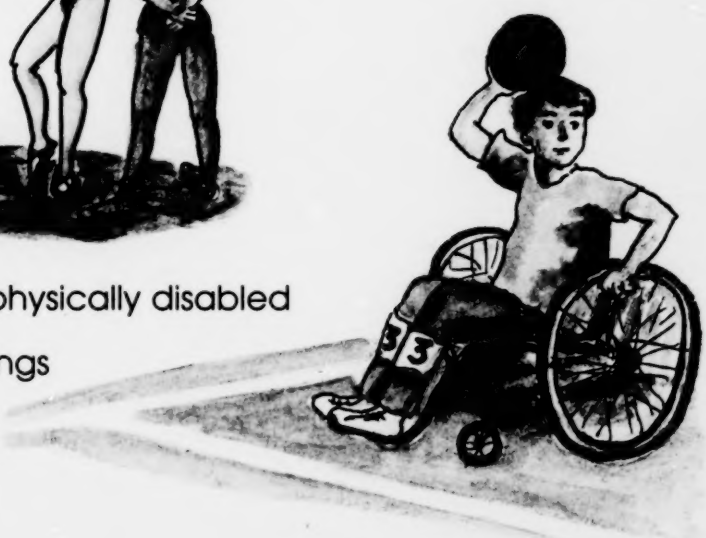
People who are blind can read with their fingers instead of their eyes.



They may use a special cane to find their way.

People who are deaf often talk with their hands, using sign language.

A person who is physically disabled can do lots of things in a wheelchair.



Physical differences are **NOT BAD**,

but they require **SPECIAL HELP**, like

"talking books"
on tape

an interpreter

speech therapy

ramps for wheelchairs

Everybody has a **BRAIN** that is different,

VERY DIFFERENT, but each of **VALUE**.

This man's brain is good at

SCIENCE

but not at writing poetry.

For him, writing is difficult.

This girl's brain is good at

MUSIC

but not at learning languages.

For her, language is confusing.

This boy is good at

PLANNING SPACE

(like architects)

but not at reading.

For him, reading is puzzling.

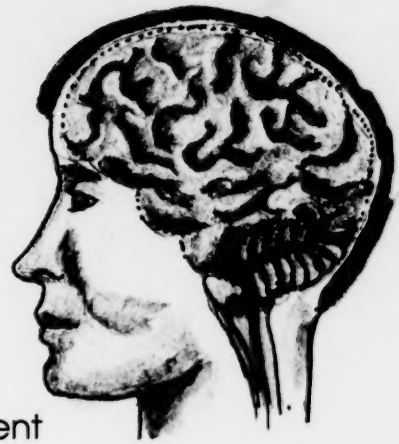
Brains are

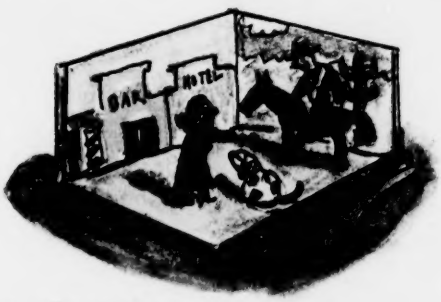
ALL GOOD,

but brains are usually not good at everything. Sometimes brains force people to find

DIFFERENT WAYS

to do things. Look at all the different ways of making a **book report**.





a diorama

There is

a written report

a film

an illustration

an oral report

and a flip book.

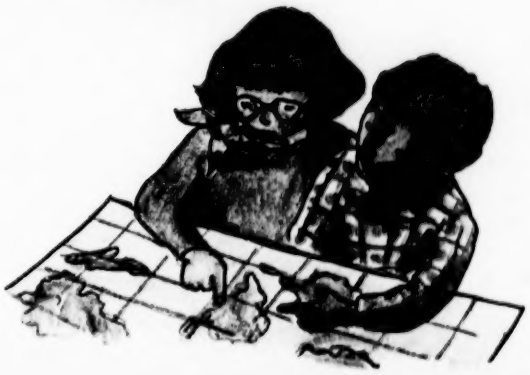
All of us are **GOOD** at **DIFFERENT** things,

VERY DIFFERENT, but each of **VALUE**.

DIFFERENT

often means a

SPECIAL ABILITY.



REMEMBER:

Different is NOT BAD
NOT DUMB
NOT WEIRD
NOT STUPID
Different is NOT NERDY

Different can be a **NUISANCE**

when you

can't **READ**,

can't **CONCENTRATE**,

don't know

UP

from

DOWN

or

RIGHT from **LEFT**,

can't

SPEAK CLEARLY,

or can't

understand

NUMBERS.

The **NUISANCES** can make you feel

ANGRY

DEPRESSED

GUILTY **NO GOOD**

like wanting to **HIDE** from shame,

like **PICKING** on others,

OR

nuisances can make you feel

MORE DETERMINED THAN EVER to succeed.

DIFFERENT

often makes you feel like a patchwork quilt

of abilities and nuisances,

of **CAN DOs**

and **CAN'T DOs**.

Everybody has a

different-looking quilt.

THEY ARE ALL GOOD.

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People who have difficulty

LEARNING IN SCHOOL

may need special help, like

equipment

a tutor

different activities

or a special class.

College students with learning disabilities

often have

a special class,

different equipment,

or a tutor

and THEY SUCCEED.

They learn **HOW to** get along differently and they learn to feel **GOOD** about being **DIFFERENT**, to feel **GOOD** about **THEMSELVES**.

Some famous people in history lived in different **COUNTRIES**, had different **HOUSES**, **CLOTHES**, **FACES**, **BODIES**, and **BRAINS**, **ABILITIES** and **DISABILITIES**. For example

Thomas Edison, who invented the electric light bulb, was learning disabled.

Ludwig von Beethoven composed some of his greatest music while deaf.

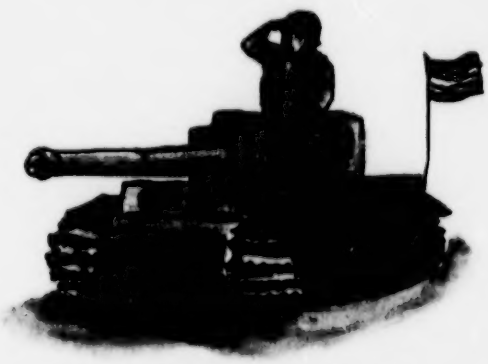
Auguste Rodin, a French sculptor who carved "The Thinker," was thought to be learning disabled.

Franklin D. Roosevelt, a President of the United States, was physically disabled.

Helen Keller earned a Master's degree and became a writer while deaf and blind.

Nelson Rockefeller, a Vice President of the United States, was learning disabled.

Leonardo da Vinci, the Italian artist who painted the "Mona Lisa," was thought to be learning disabled.



General George Patton, a great strategist who helped to win World War II, was learning disabled.

They had to work **HARDER** and **LONGER**. They had to make the **MOST** of what they did **WELL**.

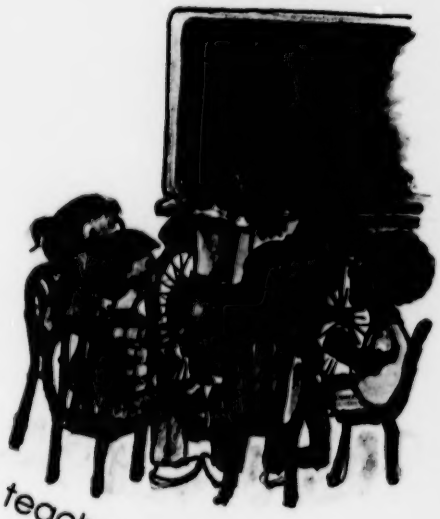
There are also lots of people who are **NOT FAMOUS**, who have great abilities as well as disabilities, who enjoy

HAPPY,

SUCCESSFUL

LIVES.

the head of a bicycle factory



a teacher

a disc jockey

an earth mover

a soldier

a dental assistant

a boutique manager

an optician

a firefighter

a hair stylist

People need to know their own **STRENGTHS** and **WEAKNESSES**.

They need to make their **OWN** quilts of **CAN DOs** and **CAN'T DOs**.

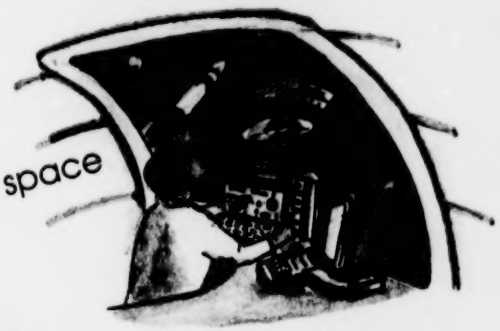
All **DIFFERENT**. All **GOOD**.

People who are different

often **SOLVE PROBLEMS** differently.

They become **VALUABLE PROBLEM SOLVERS.**

all sorts of problems



in space

medical research

the environment

peace keeping

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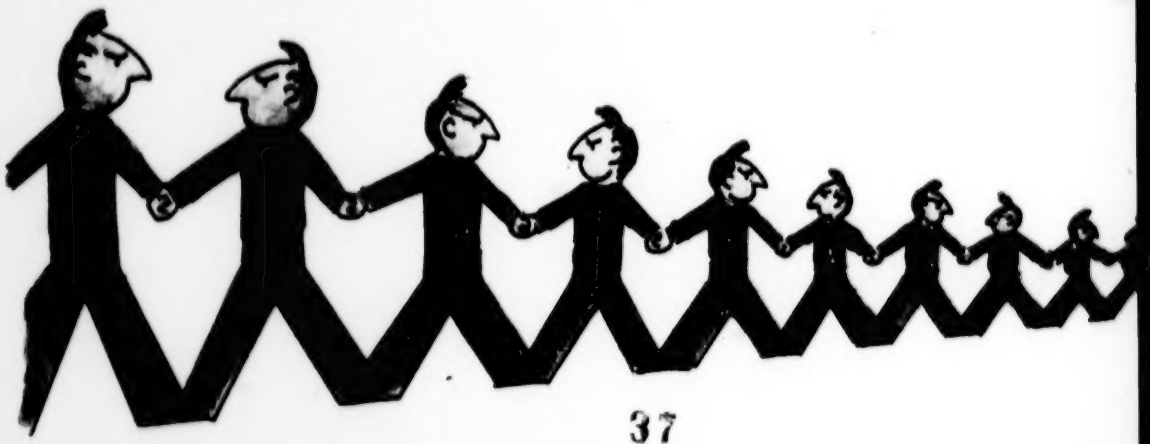
Different is **NOT BAD**.

In fact, different is GOOD.

to be **PRIZED**.

Different is **the** WORLD.

How **boring** it would be if we were all the same!



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IDENTIFIERS	Case Management

ABSTRACT

This document presents a review of recent research literature on eight components in a system of care for children with serious emotional disturbances. It is intended to be a guide and source of information to communities for building systems of care. Components include: residential services (psychiatric hospitals and residential treatment centers), outpatient services (psychotherapy), day treatment services, family preservation services, therapeutic foster care, crisis and emergency services, case management/individualized care, and family support services. The review of each component consists of definitions, summaries of outcome and empirically based efficacy studies, cost-effectiveness data, and (for most components) research needs. Generally, only studies published since 1988 were included. (Each chapter contains references.) (JDD)

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Components of a System of Care

WHAT DOES THE RESEARCH SAY?

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Vestena Robbins Rivera & Krista Kutash

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Department of Child & Family Studies
Florida Mental Health Institute
University of South Florida

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Introduction

During the past decade, a number of changes have occurred in the way we serve children with serious emotional disturbances and their families. This period of transition has been described as involving a shift in both conceptualization and practice (Duchnowski & Kutash, 1993; Knitzer, 1993). Knitzer (1993) described four shifts as relating to families, intensity of services, cultural sensitivity, and the development of community-based systems of care. The first shift involves a new conceptualization of the role of the family. Traditionally, families have been viewed as the "cause" of the problems experienced by their children. However, over the past decade, active efforts to eliminate this stereotype and attempts to have families participate more fully in the treatment planning process for their children have begun. A second shift involves a transformation in the conceptualization of service intensity. Until recently, intensive services were thought to be possible only by placing children in secure residential settings away from their parents and community. Currently, the development of new services, such as family preservation and individualized, wrap-around services, has

Introduction

allowed children to receive intensive services in a natural setting. The third shift pertains to the development of culturally competent service delivery systems. The development of culturally sensitive services requires an acknowledgment of cultural differences as well as the formulation of services which meet the needs of families of color. The fourth shift is concerned with the building of community-based systems of care. The system of care model proposed by Stroul and Friedman (1986, 1994) is based on the belief that services are to be provided in the least restrictive setting that is appropriate to the needs of the child and family. A comprehensive and coordinated array of services ranging from residential to nonresidential settings must be in place to successfully meet the individual needs of the child and family. The model presents a framework comprised of seven major dimensions of service—mental health, social, educational, health, vocational, recreational, and operational—each representing an area of need for children and families. Within each of the service dimensions is an array of service components which serve as building blocks within the system of care. For example, the mental health dimension consists of both nonresidential (e.g., outpatient services, day treatment) and residential services (e.g., therapeutic foster care, inpatient hospitalization).

It is noteworthy that Stroul and Friedman (1986, 1994) have given research an important role in the development of their system of care model. This model is "designed to be a guide, based on the best available empirical data and clinical experience to date. It is offered as a starting point . . . as a baseline from which changes can be made as additional research, experience and innovation dictate" (p. 29). Burns and Friedman (1990) described two levels at which the effectiveness of a system of care for children and adolescents can be investigated. The first level of research entails the more traditional program evaluation strategies of examining and describing the feasibility, acceptability, and general usefulness of an intervention. Models, challenges, and designs for this level of research have been published and disseminated (see Bickman, 1992; Kutash, Duchnowski, Johnson, & Rugs, 1992; Stroul, 1993). The second level of research used to examine the efficacy of a program requires a controlled experiment in a natural setting. The present review provides an overview of the available

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literature using this latter type of research.

Burns and Friedman (1990) conducted a review of the research base for child mental health services and concluded that although there had been an expansion in research which examines children's mental health services, a considerable degree of additional research was needed. One part of the research agenda focused on the examination of the effectiveness of the components within a system of care. More recently, Burns (in press) again suggested that evaluation and research on the components within a system of care are essential building blocks within the system of care philosophy.

The purpose of this current investigation was to add to the literature review conducted by Burns and Friedman (1990) as well as to serve as a guide and source of information to communities for building systems of care. A review of recent research literature on eight components in a system of care for children was conducted and synthesized. These components included the following : residential, outpatient (psychotherapy), day treatment, family preservation, therapeutic foster care, crisis and emergency, case management/individualized care, and family support. The reviews consist of definitions of the components, summaries of outcome and empirically-based efficacy studies, and cost-effectiveness data. The sources searched included PsycLIT, ERIC, and Sociofile databases, monographs, and documents included in the conference proceedings of the Annual Research Conference on Children's Mental Health sponsored by the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, in Tampa. With some exceptions, only studies published since 1988 were reviewed. Articles and reports that are summaries of reviews and meta-analyses were included, and these reviews may reflect studies conducted prior to 1988.

Each chapter was reviewed by experts in their respective area of children's mental health, e.g., case management or day treatment. It is to these people that we owe our gratitude for their contribution of time and valuable insight into our endeavors. We would like to express our thanks to the following reviewers: Karen Blase, Barbara Burns, John Curry, Lucile Eber, Mary Evans, Glenda Fine, Steven Forness, Pam Meadowcroft, Janice Moore, Carole Pastore, Steven Pfieffer, Barbara Thomlison, John Weisz, Kathleen Wells, and Susan Yelton. Also, our gratitude is

Introduction

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The dissemination of research results to parents, service providers, and policymakers in the field of children's mental health is an important part of research that is often overlooked. It is our hope that this review of the literature on the effectiveness of the components in a system of care may stimulate and guide future research endeavors that will ultimately lead to improved services for children with serious emotional disturbances and their families.

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Introduction

Residential Services:
Psychiatric Hospitals and Residential Treatment Centers

According to Stroul and Friedman (1986), a range of both residential and nonresidential services is necessary within the children's mental health service system. A variety of settings along the continuum of care have been established to meet the mental health needs of children and youth. At the most restrictive end of the continuum are residential services. For the purpose of the following review, research on both residential treatment centers and inpatient hospitalization is included.

Residential treatment centers (RTCs) serve as an alternative to psychiatric hospitalization. These 24-hour facilities, which are not licensed as hospitals, offer mental health services to children (Tuma, 1989). RTCs vary in degree of structure as some are highly structured, while others are similar to group homes or halfway houses. They also vary with regard to the range of services provided as some offer a full range of services, while others provide only custodial care.

Inpatient hospitalization is the most restrictive setting along the continuum of care (Tuma, 1989). During hospitalization,

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the child is removed from the home and the total care of the child is undertaken by hospital staff. This service is "reserved for extreme situations, for youngsters who are showing serious acute disturbances or particularly perplexing and difficult ongoing problems" (Stroul & Friedman, 1986, p. 59). Hospitals use an array of interventions, including individual, family, and group therapy; pharmacotherapy; milieu therapy; and behavioral modification. In addition to those listed above, Dalton, Muller, and Forman (1988) suggest that treatment planning, parent training, and daily school experiences also exist within the hospital setting.

Due to the recent movement toward the establishment of a continuum of care and the increasing concern about the number of children being placed in residential treatment (Wells, 1991), psychiatric hospitalization of children has been a focus of recent attention. This concern primarily has focused upon ensuring that only those youth who require a highly restrictive placement are placed in residential settings and that an array of alternative services are available to those children who can be adequately served in a less restrictive setting. Because some children do require a highly restrictive placement setting, residential treatment services remain an integral component of a comprehensive system of care for children with serious emotional disturbance (Allen & Leichtman, 1990; Singh, Landrum, Donatelli, Hampton, & Ellis, 1994).

Due to the varying methods used to place youth in residential settings, the number of children receiving such treatment for any given year is uncertain (Yelton, 1993). However, the Select Committee on Children, Youth, and Families (1990) reported that 25,334 children were in residential care in 1986, an increase of more than 30% over a three year period.

Zimmerman (1990), summarizing survey findings reported by NIMH, stated that rapid increases in the admission of adolescents to psychiatric hospitals have occurred across the nation. During 1980, over 81,000 youth under the age of 18 were admitted for inpatient psychiatric treatment and about 55,000 of these individuals fell into the age range of 15-17 years.

Based on data from 50 states, Zeigler-Dendy (1990) and Garrison (1990) reported the following summary findings of residential service use from the Invisible Children's Project: a total of 22,472 children and youth were placed in state hospitals

with an average length of stay of about four months; a total of 4,098 children and youth were placed in out-of-state treatment facilities; and over 14,000 were served in residential treatment facilities within the state.

In a paper reviewing mental health service use by adolescents in the 1970s and 1980s, Burns (1991) reported 1986 cross sectional data for 10-18 year olds. The majority (69%) received outpatient services, while the more restrictive services, such as inpatient, residential treatment centers, and partial hospitalization facilities, served a smaller percentage. In addition, Burns conducted an investigation of service use over time (1975-1986) and found that both outpatient services and residential treatment centers had over a 60% increase in use in 1986 than in 1975. Thus, it appears that although estimates of the number of children receiving residential care vary, this component of care continues to serve a large number of children in need of mental health services.

Cost/Cost Estimates

As well as representing the most restrictive form of care for children, residential services also are the most expensive. Burns and Friedman (1990) state that psychiatric hospitalization often costs around $500 per day. With an average length of stay of approximately 30 days, this form of treatment can be expensive. Residential treatment centers also are an expensive form of treatment with costs ranging between $100 to $300 per day of care (Stroul & Friedman, 1986); however, when compared to the cost of hospitalization, this treatment approach is much less expensive.

The Invisible Children's Project (Garrison, 1990; Zeigler-Dendy 1990) was conducted as an effort to gather information on a national level regarding the number of children in residential placement settings as well as the cost of such placements. Costs estimated from the results of this project revealed an average per diem rate of about $112.00 for residential treatment programs. A total annual cost of over $200,000,000 was estimated for the 4,098 children reported in out-of-state residential placement, using cost data from the state of Indiana in the calculation. Based on detailed cost data from six states, the average daily rate for youth in state mental hospitals was about $300; thus, annual treatment costs per child would be $109,193. Based on these cost estimations, it was projected that on a national basis, treatment for the 22,472 youth in state hospitals with an average length of stay of 4.2 months would cost

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over $850,000,000. In a recent survey of financial practices, 42 of the 50 states reported the use of state hospitals as a placement for children and youth (Kutash, Rivera, Hall, & Friedman, in press). Thus, it appears that states continue to rely on the use of hospitalization which results in substantial cost to states.

Recent discussions on the financing of mental health services for children and youth have suggested that the establishment of a comprehensive continuum-of-care system would result in a dramatic reduction in the cost per child when costs are averaged for all children receiving services along the continuum (Behar, 1990). This point is further emphasized by the findings of a study conducted by Hoagwood and Cunningham (1992) in which cost estimates suggested that the implementation of a comprehensive array of services could reduce state residential and inpatient psychiatric hospitalization costs by 60 %. Promising results from the California AB377 Evaluation Project have begun to demonstrate that the implementation of a comprehensive system of care can result in overall cost savings (Attkisson, Dresser, & Rosenblatt, in press; Rosenblatt, Attkisson, & Fernandez, 1992). This project, which replicated the system of care for youth with severe emotional disturbances "pioneered" in Ventura County, has been implemented in three other California counties. Due to the high numbers of youth served in residential group homes and the subsequent cost of serving these youth, the project sought to reduce placements and costs by providing a coordinated and effective system of care. Results indicated that the demonstration counties, when compared to the state of California as a whole, reduced the number of group home placements and thus, expenditures. Similar results were obtained for the CHAMPUS Tidewater Demonstration Project (Burns, Thompson, & Goldman, 1992). This project was an attempt to reduce the use of more restrictive and costly residential services through the implementation of a partial hospitalization placement setting and a more effective monitoring system. Results revealed a shift in the use of levels of care with a greater number of children being admitted to the outpatient treatment setting over time, while admissions to inpatient treatment settings decreased over time. Thus, as the use of more costly inpatient treatment settings declined, the costs of mental health services decreased.

Despite the significantly higher cost of residential placement in comparison to other service types and the criticisms that

have characterized it as an overused and unnecessarily restrictive placement setting, this component continues to be an integral part of a comprehensive system of care as it is a necessary placement for a portion of children and youth identified as seriously emotionally disturbed (Singh, Landrum, Donatelli, Hampton, & Ellis, 1994).

Effectiveness and Outcome Research

"Recent pressure from third party payors, as well as philosophical and theoretical changes within the field of mental health, have raised questions about the appropriateness of psychiatric hospitalization of children. Increased scrutiny has underscored the need for efficacy studies to determine the utility of this form of treatment" (Dalton, Muller, & Forman, 1988, p. 232). However, little research on outcomes and effectiveness is currently available (Stroul & Friedman, 1986; Burns & Friedman, 1990).

A number of scholarly reviews of the existing literature on the efficacy and outcome of residential treatment have been completed. Blotcky, Dimperio, and Gossett (1984) summarized the findings of 24 efficacy studies conducted between 1936 and 1982 which examined the outcome of children treated in psychiatric hospitals. The following factors were found to be predictive of a positive outcome: adequate intelligence, nonpsychotic and nonorganic diagnoses, absence of bizarre and antisocial behaviors, healthy family functioning, adequate length of stay, and adequate aftercare. Most of the studies suffered from serious methodological weaknesses; thus, findings should be viewed with caution.

Dalton, Muller, and Forman (1988) reviewed two outcome studies which measured the effectiveness of specific inpatient interventions in the treatment of children with conduct disorder and antisocial behavior. The first study (N = 26) found no significant change in behavior following three months of treatment on a psychiatric unit, although some gains in social relationships were noted. The second study (N = 40) examined the combined effects of parent management training and cognitive-behavioral problem-solving skills training for children with antisocial behaviors. Both at discharge and at one year follow-up, the group receiving the inpatient intervention exhibited significantly less aggressive and externalizing behaviors at home and at school than did the control group which received no treatment.

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Burns and Friedman (1990) cited one clinical trial which compared the behavioral and educational outcomes of a group of children randomly assigned to hospitalization and community-based treatment services. Results revealed that outcomes at discharge were comparable for both groups. However, at follow-up, one-half of the hospitalized group and only one-fourth of the community-based group were in institutions. In an examination of the research base underlying the effectiveness of residential treatment centers, Burns and Friedman (1990) cited two studies which revealed no significant benefits resulting from residential treatment when compared to alternative methods, although follow-up studies on the effectiveness of RTCs generally report positive results. A third study revealed the effectiveness of a residential treatment center and found postdischarge support to be necessary for the maintenance of treatment gains.

Pfeiffer and Strzelecki (1990) provided a review of outcome studies on inpatient psychiatric and residential treatment of children and youth conducted from 1975 to 1990. It should be noted that none of the 34 follow-up studies in this review utilized random assignment of subjects (Bickman, 1992). A synthesis of the results of the 34 follow-up and outcome studies was conducted using a method developed by the authors. For a discussion of possible limitations of this technique, see Blotcky and Dimperio (1991). For each study, the relationship between outcome and a predictor variable was rated as negative, neutral, or positive; this value was then adjusted according to the sample size. Using this method, the following factors were found to be predictive of a positive outcome: the presence of a specialized treatment regimen, the availability of aftercare services, and less severe child and family dysfunction. Intelligence and length of stay were moderately predictive of a favorable outcome. Age and gender were found to be unrelated to outcome.

Cornsweet (1990) reviewed the findings of two controlled studies of inpatient treatment of preadolescent children. The first study involved children admitted to an inpatient unit and deemed appropriate for hospitalization. Children were randomly assigned to either hospital treatment (up to 6 months) or brief hospital-based evaluation followed by intensive community-based treatment. At discharge, the children were compared across various family, behavioral, and educational variables. Several methodological limitations exist with this study;

however, findings revealed that both groups improved on behavioral and educational variables, while family functioning remained constant. The second study compared the effectiveness of a cognitive-behavioral problem-solving skills approach to nondirective relationship therapy in the treatment of children with antisocial behaviors admitted to an inpatient unit. An attention-only control group received contact but no efforts were made to address problems or affective issues. Children were randomly assigned to one of the three groups. Discharge and follow-up results obtained at three points in time revealed greater behavioral gains for the group receiving problem-solving skills training when compared to the group receiving relationship therapy and the attention-only control group.

Curry (1991) provided yet another review of the available outcome research on the residential treatment of children and youth. In his review of studies using single-sample designs, Curry included both hospital-based and residential treatment-based studies. The results of the hospital-based studies suggested that outcomes vary. That is, while many children improve, others show no improvement and a small percentage may reveal "seriously negative outcomes" at follow-up. The importance of support and aftercare following discharge was emphasized. Curry then summarized the findings of three residential treatment-based studies. Briefly, the first study found that subjects' adaptation improved during treatment and that the majority (71%) were functioning adequately at follow-up. The second study revealed an association between adaptation following discharge and the child's perception of support and continuity. A third study demonstrated that while most of the children treated in the residential treatment center showed improvement during treatment, treatment gains were not predictive of later adjustment. Due to the nature of single-sample designs, these studies failed to address the question of effectiveness but did contribute to the existing knowledge base.

The results of four studies utilizing more powerful comparative designs were reviewed (Curry, 1991; see also Quay, 1986, for a review of these studies). The first study, Project Re-Ed, is an example of a between program study using treatment-no treatment groups. The treatment group received direct treatment from specially trained teachers, while also involving the child's family and school. Findings revealed that those receiving treatment

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fared better than those in the no-treatment group; however, only about 50% of the children received a change in their special education placement category of severely behaviorally impaired. The Close-Holton Study serves as an example of a between-program study using between-treatment groups. The Close School utilized a transactional analysis group approach, while the Holton School employed a behavioral modification treatment approach. This study did not reveal major differences in treatment effectiveness based on type of treatment approach. The Balderton Hospital Study, a within-program study using a between-treatment design, focused on the treatment of adolescents on probation using two types of alternative treatment approaches: a self-governing group therapy program and an authority-based program. At follow-up, those in the authority-based treatment group had committed fewer offenses than those in the self-governing group. The last study reviewed by Curry was the California Community Treatment Project, an example of an across-program study design. This study was designed to test whether those delinquents viewed as in need of residential services actually did better when they received it. Subjects deemed in need of residential services were randomly assigned to either residential treatment or community-based treatment. For those judged in need of residential care, results revealed a lower rate of rearrest for those receiving residential treatment than for those not receiving it.

A number of studies conducted from 1988 to the present and not included in the reviews above are described. Ney, Adam, Hanton, and Brindad (1988) conducted a one-year follow-up study to determine the effectiveness of a child psychiatric unit. The 10-bed facility provided treatment for the full range of children with psychiatric problems. The children ($N = 112$) involved in the study represented a variety of presenting problems, with the majority having a diagnosis of conduct disorder. Other diagnoses included encopresis, anorexia, major depression, psychomotor epilepsy, autism, fire setting, and various symptoms resulting from abuse and neglect.

Prior to hospitalization, children underwent a 2-week assessment process conducted in the home and school settings. Treatment plans were established on the first day of admission. The facility provided a five-week inpatient program and a five-week follow-up period. A combination of 65 treatment techniques developed on an individual basis for each

child was implemented by staff. The children's friends and family were involved in the hospitalization process. Parents attended weekly seminars and were taught a variety of child management techniques.

Following inpatient treatment, changes in the functioning of parents and children involved in the study ($N = 112$) were assessed. The majority of parents indicated that they were more frequently able to talk and to listen to their child. At one year postdischarge, about 84% of the parents reported that the program was very helpful, 8% reported that treatment made no difference, and 4% indicated that problems had escalated as a result of the program. Sixty-four percent of the families indicated that the whole family was managing better as a result of treatment. The parents indicated that they became angry, lost control, or criticized their children on a less frequent basis and reported the acquisition of more effective discipline skills. Although some were not statistically significant, outcome measures for the children revealed changes in the positive direction. A large improvement in the number of police contacts was not witnessed; however, the number of children involved in this behavior was minimal. Significant changes in the five scales of the Peterson-Quay Behavior Problems Checklist were noted. Ninety-seven percent of the children returned to the families from which they were admitted. A two percent readmission rate was observed over the three year history of the program.

A one-year follow-up report on the effects of long-term hospital treatment of children and adolescents was conducted by Berland and Safier (1988). Subjects were patients at the Children's Hospital of The Menninger Clinic, a long-term treatment facility. Upon admission, each patient received a full diagnostic examination, including a psychiatric examination, family assessment, psychoeducational assessment, psychological evaluation, and recreational, nutritional, speech and hearing, physical, and neurological examinations. Patients were placed on a unit which had an assigned director (child psychologist or psychiatrist), a social worker, and child care workers. There was an accredited school on site and nearly all patients received individual psychotherapy. The treatment philosophy of the program was rooted in dynamic psychiatry based on psychoanalysis, developmental psychology, and family systems.

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Patients (N = 42) were grouped into three major diagnostic categories: psychoses, personality disorders, and neuroses. Results, obtained from telephone interviews with youth and parents, revealed that more than two-thirds had a positive outcome at one year follow-up and almost 75% of those with personality disorders had improved. Although follow-up revealed that most of these children did make adequate adjustments following discharge, the results should be viewed with caution due to the small sample size.

Blumberg (1992) conducted a study to assess the general treatment effects of an inpatient/day program unit of a children's psychiatric hospital. The hospital provided a behavioral treatment milieu, including tokens, time out, and locked seclusion. Subjects (N = 115) exhibited severe emotional and/or behavioral problems that required a restrictive environment. Parents and teachers completed a standardized behavior checklist to assess general level of functioning at time of admission, three months after admission, six months following discharge, and one year postdischarge. Results revealed that the children's behavior tended to improve following treatment in the hospital. Poor initial response to treatment as well as a diagnosis of ADHD were predictive of poor outcome.

A more recent follow-up study was conducted to determine short-term outcomes for sixty-five children discharged from a child psychiatric unit (Kalko, 1992). The children received the following primary diagnoses: conduct disorder, ADHD, major depression/dysthymia, oppositional disorder, anxiety disorder, adjustment disorder, and other mental disorders. During hospitalization, children were exposed to several therapeutic interventions, including a behavioral unit-wide point system, group therapy, medication, cognitive-behavioral skills training, consultation services, family counseling, and parent training. Outcomes were evaluated at two, four, and six months after discharge by parent reports obtained during a structured telephone interview. Analyses of variance revealed no significant effects by follow-up interval or length of stay. Based on parent ratings of their child's behavior for the 24 hours prior to the follow-up interview, children were classified as high or low in follow-up improvement. Based on the literature, predictor variables from three domains were selected for examination: background or diagnostic characteristics; family; and treatment. Poor short-term outcome was found to be predicted by the following variables:

diagnosis of ADHD, older age at admission, child depression or sadness, neurological or psychotic symptoms, limited aftercare services, history of physical abuse, and higher intellectual level. High improvement children were reported to have exhibited greater reductions in externalizing and internalizing behaviors. Parents also acknowledged a more positive adjustment at home. Measures of consumer satisfaction indicated that most children showed some significant change and that individual or group treatment was perceived as the most beneficial intervention for children. However, the services received did not differ as a function of the child's perceived improvement.

In a study designed to investigate the outcomes for children with serious emotional disturbances who were placed in residential treatment for educational purposes, Hoagwood and Cunningham (1992) collected data over a three year period (1987-1990) for 114 students. An analysis of outcome ratings indicated that in over 60% of the cases, no or minimal progress had been made or the student had been discharged with a negative outcome (i.e., had run away). In 25% of the cases, students revealed a positive outcome (i.e., returned to school or school-related vocational training). In 11% of the cases, students remained in residential placement but had made substantial progress. Analyses revealed that positive outcomes were significantly related to shorter lengths of stay, with positive outcomes most likely to occur if the youth was discharged prior to 15 months. No significant relationship was observed between age at placement and outcome or cost per month and outcome. The majority of the respondents (over 2 out of 3 subjects) stated that the availability of community-based services such as day treatment, respite care, intensive in-home family support, and crisis intervention, would have prevented residential placement.

Conclusions and Future Research Needs

Based on the present literature review (see Table 1), it appears that the features of residential treatment vary widely. The residential programs described in this review comprised a wide assortment of placement settings, therapeutic modalities, program components, and costs. Thus, it is difficult to determine those features of residential treatment that are most effective in producing successful outcomes. Although the features of residential treatment vary, one

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traditionally held perception was that this method of service delivery represented the most restrictive and thus, the most *intensive* form of treatment along the continuum of care. However, during the past decade the service delivery field has experienced a shift in this perception of intensity. That is, appropriate levels of intensive service can be rendered in the child's natural environments through the provision of family preservation and individualized, wraparound services. Thus, home and community-based approaches as well as residential services are now considered to be appropriate avenues for the provision of intensive services (Knitzer, 1993).

Studies on the outcomes and efficacy of residential treatment of children vary widely in their focus and methodology. The majority of research studies presented in the current review did not examine residential care in comparison to other service approaches, but rather focused on the factors relating to outcome. Factors found to be predictive of positive outcome included adequate intelligence; nonpsychotic, nonorganic diagnoses; the absence of bizarre and antisocial behaviors; healthy family functioning; adequate length of stay; and adequate aftercare (see Blotcky, Dimperio, & Gossett, 1984). Based on their review of 34 studies, Pfeiffer and Strzelecki (1990) found the following factors to be related to a positive outcome: a standardized treatment regimen, aftercare services, and less severe child and family dysfunction. Length of stay and IQ were found to be moderately predictive of positive outcome. Hoagwood and Cunningham (1992) found that shorter lengths of stay were associated with positive outcomes. Other studies have documented factors found to be predictive of poor outcome. Blumberg (1992) found that a diagnosis of ADHD and poor initial response to treatment were associated with poor outcome. Kalko (1992) also found that a diagnosis of ADHD was predictive of poor outcome as well as older age at admission, child depression or sadness, neurological or psychotic symptoms, limited aftercare services, history of physical abuse, and higher intellectual functioning.

Other studies included in this review compared residential treatment services to no-treatment groups. Generally, these studies found that youth receiving residential services experienced more positive outcomes than youth receiving no services. There are a limited number of studies which examined the effectiveness of residential services as compared to other methods of service delivery.

Currently, no conclusive evidence exists to support the effectiveness of residential treatment over other service types.

Despite the wide variability among residential treatment programs and a lack of rigorously controlled studies, residential treatment services have been found to result in improved functioning for *some* children. Residential treatment plays a significant role in the treatment of children and youth with serious emotional disturbances. However, considerable research is needed before conclusive statements regarding the effectiveness of residential services can be drawn. Future research efforts must concentrate upon determining which youth can most benefit from this type of treatment as well as those treatment approaches which work best with specific populations of children and youth.

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Table 1
Overview of Studies Examining the Effectiveness of Residential Services

Author or Reviewer	Type of Article	Design	Results/Conclusions
Blotcky, Dimperio, & Gossett (1984)	Summarized 24 outcome studies conducted between 1936 - 1982.	Outcomes of psychiatric hospitalization; single sample design.	Factors predictive of positive outcome: Adequate IQ; nonpsychotic non-organic diagnoses; absence of bizarre & antisocial behaviors; healthy family functioning; adequate length of stay; and adequate aftercare
Dalton, Muller, & Forman (1988)	Reviewed two outcome studies of inpatient treatment.	Single sample design: 1) Outcome of children receiving treatment for conduct disorder and antisocial behavior 2) Skills training vs. no-treatment control	1) Following three months of inpatient treatment, some gains in social relations as measured on a behavioral rating scale, but no significant change in other behaviors. 2) Skills based treatment group receiving treatment in inpatient setting exhibited less aggression and externalizing behaviors than no treatment control group.
Burns & Friedman (1990)	Reviewed results of 4 studies	1) Randomly assigned to treatment & control groups 2) RTC vs. alternative treatment method 3) RTC vs. alternative treatment method 4) RTC	1) No difference between groups at discharge. At follow up, hospitalized youth were twice as likely to be in institution. 2) No significant benefits from residential treatment when compared to alternative. 3) No significant benefits from residential treatment when compared to alternative. 4) Support for the effectiveness of RTC. Post discharge support necessary to maintain treatment gains.
Pfeiffer & Strzelecki (1990)	Reviewed and assessed outcome of 34 studies conducted between 1975 and 1990 which examined inpatient psychiatric and residential treatment of children.	34 follow-up single-sample studies.	Factors found to be predictive of positive outcome: standardized treatment regimen; aftercare services; less severe child and family dysfunction. Factors found to be moderately predictive of positive outcome: IQ and length of stay.
Cornsweet (1990)	Reviewed two controlled studies of inpatient treatment.	Random assignment of groups: 1) Hospital vs. hospital-based evaluation/intensive community-based treatment 2) Problem-solving skills training vs. relationship treatment vs. attention-only control group	1) Both groups improved on behavioral and educational variables; family functioning remained constant. 2) At discharge and follow-up, improved behavioral gains for problem-solving skills training group as compared to groups receiving relationship therapy and attention-only.
Curry (1991)	1) Reviewed hospital-based studies 2) Summarized 3 residential treatment-based studies	1) Single sample designs 2) Single sample & follow up	1) Outcomes vary; many improved, others experienced no improvement, and a small percentage displayed negative outcomes. Support and aftercare services are important. 2a) Improved during treatment and majority were functioning adequately at follow-up. 2b) An association was found between adaptation following discharge and the child's perception of support and continuity. 2c) Most children showed improvement during treatment, treatment gains were not predictive of long-term adjustment.

Table 1, continued

Author or Reviewer	Type of Article	Design	Results/Conclusions
Curry (1991) & Quay (1986)	Reviewed 4 studies.	1) Between program study using treatment-no treatment groups 2) Between-program study using between-treatment groups 3) Within-program study using a between-treatment design 4) Across-program study design	1) Those receiving treatment fared better than the no-treatment group; only 50% received a change in their special education placement category of severely behaviorally impaired. 2) No major difference found between groups receiving transactional analysis and behavior modification treatment approaches. 3) Those in the authority-based treatment group committed fewer offenses than those in the self-governing group. 4) For those youth deemed as in need of residential care, results revealed a lower rate of rearrest for those receiving residential treatment than for those receiving community-based treatment.
Ney, Adam, Hanton, & Brindad (1988)	Examined effectiveness of a child psychiatric unit (N = 112).	One year follow-up study.	Majority of parents were more frequently able to talk and listen to child. At one-year follow-up, 85% viewed the program as helpful, 8% reported that treatment made no difference, and 4% reported that problems increased following treatment. 64% indicated greater family functioning. Outcome measures for the children revealed changes in the positive direction. 97% of the children returned to their families. A 2% readmission rate was observed over the three year history of the program.
Berland & Safier (1988)	Examined long-term hospital treatment of children and youth (N = 42) at Children's Hospital of The Menninger Clinic.	One year follow-up study.	More than 2/3 of the group had a positive outcome at one year follow-up and almost 75% of those with personality disorders improved.
Blumberg (1992)	Examined effectiveness of an inpatient/day program unit of a children's psychiatric hospital (N = 115).	Single sample study.	Results revealed that the children's behavior tended to improve following treatment in the hospital. Poor initial response as well as a diagnosis of ADHD were predictive of poor outcome.
Kalko (1992)	Investigated short-term outcomes for children (N = 65) discharged from a child psychiatric unit	Follow-up study. Single sample.	No significant effects by follow-up or length of stay. Poor short-term outcome was predicted by a diagnosis of ADHD; older age at admission; child depression or sadness; neurological or psychotic symptoms; limited aftercare services; history of physical abuse; and higher intellectual functioning. Parents reported a more positive adjustment at home. Services did not differ as a function of the child's perceived improvement.
Hoagwood & Cunningham (1992)	Outcome data for N = 114 students placed in residential treatment for educational purposes.	Outcome study. Single sample.	In 25% of the cases, a positive outcome was revealed (returned to school or school-related vocational training). Over 60% experienced no or minimal progress or was discharged with a negative outcome (running away). In 11% of the cases, students remained in residential placement but made progress. Positive outcomes were associated with shorter lengths of stay (less than 15 months).

Outpatient Services: *Psychotherapy*

The most commonly utilized mental health service component for children is outpatient therapy[1]. Although there is no widely accepted definition, psychotherapy has been defined by Kazdin (1991) as "an intervention designed to decrease distress, psychological symptoms, and maladaptive behavior or to improve adaptive and prosocial functioning" (p. 785). Outpatient therapy is the least restrictive component along the continuum of care and is usually the first and most frequent type of treatment provided to children and families in need of service (Tuma, 1989). Psychotherapy varies with regard to theoretical approach ranging from psychodynamic, to behavioral or cognitive-behavioral, to a systems approach. In more recent years, a combination of the various approaches is used frequently. Outpatient therapy also occurs in a variety of settings that may include community mental health centers, outpatient psychiatry departments of hospitals, or private offices and is most often provided by psychiatrists, psychologists, social workers, and counselors.

[1] *For the purposes of this paper, the terms "outpatient therapy" and "outpatient services" are used to refer only to psychotherapy, not to forms of therapy that involve the dispensation of medication.*

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Typically, the child and/or family will receive therapy in an office on a regular basis (Stroul & Friedman, 1986). Thus, outpatient therapy allows a child to remain in his or her home, school, and community while continuing to receive mental health services (McKelvey, 1988).

Due to the wide variety of settings in which outpatient services are delivered, it is difficult to obtain an accurate estimate of the number of children receiving such services. In an examination of mental health service use by adolescents in the 1970s and 1980s, Burns (1991) reported 1986 cross-sectional data for 10- to 18-year olds. The results revealed that the majority (69%) of adolescents who received treatment were served in outpatient settings. Residential treatment centers, inpatient services, and partial hospitalization services were used by a much smaller percentage of adolescents with 8%, 22%, and 3%, respectively. Burns further examined shifts in the use of services over time. In 1975, a total of 228,584 outpatient admissions (68% of the total admissions to mental health services) were reported as compared to 371,307 (69%) in 1986. Thus, an overall growth rate of 62% in the number of admissions to outpatient services was evident from 1975 to 1986.

Along with a variety of social services, psychotherapy is an intervention that commonly is used in the treatment of children and youth with emotional and behavioral problems (Kazdin, 1993). Although outpatient therapy has an extensive efficacy literature, little attention has been given to the effectiveness of this service in the treatment of children and youth with serious emotional disturbance (Burns & Friedman, 1989, 1990). The purpose of this paper is to provide a brief overview of a number of scholarly reviews of studies examining the effectiveness of child and adolescent psychotherapy. For a more detailed and indepth discussion of the issues related to outpatient care for children, the reader is referred to Weisz and Weiss (1993).

Effectiveness and Outcome Research

Review by Eysenck

The earliest review of the effectiveness of psychotherapy was conducted by Eysenck (1952). Based on this review, Eysenck concluded that the use of psychotherapy in the treatment of adults resulted in no greater improvements than those that occurred in the absence of treatment. Although a limited number of studies involving children were included, this initial review led to further investigations of the effectiveness of psychotherapy for

children and adolescents (Kazdin, 1991).

Review by Barrnett, Docherty, and Frommelt

In a review of child psychotherapy research conducted since 1963, Barrnett, Docherty, and Frommelt (1991) presented a summary of four reviews. In the earliest review, Levitt noted that the results did not lend support to the use of psychotherapy in the treatment of children. A later review conducted by Wright and his colleagues found that successful outcome status was apparent between termination and follow-up, and that improvement was positively correlated with the number of therapy sessions attended. In 1980, Tramontana reviewed the adolescent psychotherapy literature for the period of 1967-1977. Thirty-three studies of individual, group, and family therapy were included, although only five of the studies were determined to have employed adequate methodologies. Despite this lack of methodologically sound studies, Tramontana concluded that psychotherapy was effective when compared to no treatment. During the same year, Smith and her colleagues examined control studies using meta-analysis[2]. The analysis revealed that those receiving psychotherapy had significantly better outcomes than those in the control condition.

Review by Weisz and colleagues

Weisz and his colleagues (Weisz, Weiss, & Donenberg, 1992; Weisz, Donenberg, Han, & Kauneckis, in press) reviewed four meta-analyses examining the effectiveness of psychotherapy with children and youth. The first meta-analysis reviewed was conducted by Casey and Berman and included 75 studies published during the period of 1952 and 1983. Studies involved children with a wide range of presenting problems and included a variety of theoretical approaches. Results indicated that children who received psychotherapy showed greater improvement following treatment than 76% of children who received no treatment.

The second meta-analysis was conducted by Weisz, Weiss, Alicke, and Klotz (1987) and involved a total of 105 outcome studies published between the years of 1952 and 1983. Children included in these studies were between the ages of 4 and 18 years and the majority exhibited

2 Meta-analysis developed by Glass, McGaw, & Smith (1981) is a "set of quantitative procedures that can be used to evaluate multiple studies" (Kazdin, 1991, p. 786). An effect size, the calculated difference between means of a treatment and control group and divided by the standard deviation of the control group, is computed which then provides a summary statistic that allows for the impact of other variables to be examined.

either an internalizing or externalizing disorder. Both behavioral and nonbehavioral interventions were used, with the majority involving a behavioral approach. Similar to the findings of Casey and Berman, the results revealed that children receiving psychotherapy functioned better following treatment than 79% of those in the control group. It was further concluded that behavioral treatments proved to be more effective than nonbehavioral approaches. It should be noted that this conclusion has been questioned by others in the field who, based on reviews of the nonbehavioral literature, stated that "such comparisons are, at best, premature" due to a lack of methodologically sound research (Shirk & Russell, 1992, p. 707). Similarly, in a review of 43 nonbehavioral (traditional verbal and play therapy) child psychotherapy research studies conducted since 1963, Barrnett, Docherty, and Frommelt (1991) concluded that a large number of methodological flaws were apparent which restricted the accuracy of conclusions regarding the efficacy of these nonbehavioral approaches.

The third meta-analysis included in the review was conducted by Kazdin, Bass, Ayers, and Rodgers and involved studies published between 1970 and 1988. Studies utilized a variety of intervention approaches and involved children who exhibited internalizing, externalizing, and learning-academic problems. A total of 105 studies comparing treatment and control groups were analyzed. For studies involving treatment versus no treatment groups, children who received treatment exhibited greater improvement than 81% of those in the control group. For those studies comparing treatment and "active" control groups, children who received treatment functioned better than 78% of those in the "active" control group.

Lastly, preliminary data resulting from a meta-analysis conducted by Weisz, Weiss, Morton, Granger, and Han were reviewed. This comprehensive review incorporated 110 studies published between 1967 and 1991 which involved children ages 2 to 18 years. The majority of children exhibited either externalizing or internalizing problems, and the majority of studies involved the use of behavioral interventions. Meta-analytic procedures revealed that following treatment, children receiving psychotherapy functioned better than 76% of those in the control group.

Review of specialty meta-analyses by Weisz et al.

Five specialty meta-analyses were reviewed by Weisz and his colleagues (Weisz, Weiss, & Donenberg, 1992; Weisz, Donenberg, Han, & Kauneckis, in press). These studies included an examination of the effectiveness of family therapy as conducted by Hazelrigg, Cooper, and Borduin; a review of studies investigating the effectiveness of cognitive-behavioral therapy with 4- to 13-year olds conducted by Durlak, Fuhrman, and Lampman; a review of outcome studies which examined the effectiveness of self-statement modification (SSM) with children aged 5 to 16 years conducted by Dush, Hirt, and Schroeder; a review of outcome studies examining the efficacy of cognitive-behavioral methods in the treatment of child impulsivity conducted by Baer and Nietzel; and a recent exploration of the impact of child psychotherapy on the language proficiency of children conducted by Russell, Greenwald, and Shirk. Each of these studies provided evidence to support the efficacy of psychotherapy.

As can be seen, meta-analyses have provided a *general* conclusion supporting the effectiveness of psychotherapy with children and adolescents. However, Weisz, Weiss, and Donenberg (1992) have stated that such a conclusion may be "premature." That is, the treatment conditions under which these studies have been conducted are not representative of standard clinic-based therapy. Thus, it is not known whether the findings derived from the studies conducted under "controlled laboratory settings" can be generalized to therapy conducted in clinics. To that end, Weisz and his colleagues (Weisz & Weiss, 1993; Weisz, Donenberg, Han, & Kauneckis, in press; Weisz, Weiss, & Donenberg, 1992) reviewed the findings of several clinic-based studies which met certain specifications (see Weisz, Donenberg, Han, & Kauneckis, in press, for a description of the criteria used to select studies for inclusion in the review).

Review of clinic-based studies by Weisz et al.

The first study reviewed was conducted by Shepherd, Oppenheim, and Mitchell in 1966 and examined matched pairs of treated children with children in the general population ($N = 50$ pairs). At two years following initial assessment, in-home clinical interviews revealed improvements for 63% of the clinic cases and 61% of the nonclinic cases. There was

no relationship between the number of treatment sessions and subsequent improvement.

A study by Witmer and Keller was reviewed which compared the outcomes of children who received treatment (n = 85) with those who received only a diagnostic evaluation (n = 50). The two groups were followed for a period of 6 to 13 years following contact with a child guidance clinic. Results indicated that 28% of the treated children were rated as *successful* as compared to 48% of those who received only a diagnostic evaluation. A greater percentage (30%) of individuals in the evaluation-only group were rated as *improved*, while 26% of those in the treatment group received such a rating. Overall, those who received only an evaluation had better long-term outcomes than those who received treatment.

Weisz and his colleagues reviewed four clinic-based studies conducted by Lehrman, Sirluck, Black, and Glick in 1949; Levitt, Beiser, and Robertson in 1959; Ashcraft in 1971; and Jacob, Magnussen, & Kemler in 1972. These studies were designed to compare treated and untreated children, both of which had been admitted to the same facility during the same period of time but with those in the control group comprised of children who dropped out before receiving treatment. The earliest study found that at one year follow-up, the percentage of cases classified as being successful were significantly higher for those who received treatment (n = 196) than for those in the control group (n = 110), while the percentage of cases rated as failures were greater for those in the control group. The second study assessed outcomes on 26 variables approximately five years following clinic contact. No significant differences were noted between the treatment group (n = 237) and the control group (n = 93). Further, no differences were found between the control group and those in the treatment group who received ten additional therapy sessions. The third study consisted of a five-year follow-up study of children receiving treatment (n = 40) and those who dropped out before treatment (n = 43). Outcomes were assessed using measures of academic achievement, as these children had been classified as academic underachievers. No differences were noted between the two groups on any outcome measure. The fourth study compared 45 children who received treatment to 42 children who terminated before receiving treatment. Outcome comparisons conducted at one and two-

year follow-up periods revealed no significant differences between the groups.

Weisz and Weiss (1989) conducted a recent study investigating the efficacy of clinic-based treatment by examining the outcome of treated youth and those who terminated before treatment. In this study, youth (n = 93) from nine clinics who completed a six month course of therapy were compared with youth (n = 60) who dropped out of treatment following an intake evaluation. Outcomes were assessed at intake, 6 months following intake, and again at one year. Outcome measures included the completion of the Child Behavior Checklist (CBCL) by parents, the parents' identification of the three major problems experienced by their child and the severity of these problems, and the completion of the CBCL Teacher Report Form (TRF) for a subsample of the youth. Results revealed no significant differences in the groups on any measure at six months or at one year following intake.

Two clinic-based studies which utilized random assignment were reviewed by Weisz, Donenberg, Han, and Kauneckis (in press). DeFries, Jenkins, and Williams matched pairs of foster care children who were seriously disturbed on a number of demographic and clinical factors. One member of each pair was randomly assigned to receive standard foster care services while the other group received psychotherapy and enhanced foster care services. Following therapy, children were rated as *improved*, *no change*, or *worsened*. No significant differences were noted between the two groups. Further, institutionalization occurred more frequently among those in the treated condition as compared to those in the comparison group. A second and more recent study conducted by Smyrnios and Kirkby utilized a random-assignment study. A total of 30 clinic-referred children and their parents were placed in either time-unlimited or time-limited (12 sessions) psychodynamic therapy or a control group that received minimal contact. Following termination and at 4 year follow-up, some outcome measures revealed no significant differences between the treatment and control groups. Some measures indicated more positive outcomes for those in the minimal contact group than for those in the unlimited treatment group.

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Conclusions and Future Research Directions

In general, most laboratory-based studies examining the effectiveness of psychotherapy for children found an overall positive effect of treatment. However, it has been argued that these laboratory-based studies failed to accurately represent how therapy and treatment are carried out in "real world" clinic-based settings (Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, 1988; Weisz, Donenberg, Han, & Kauneckis, in press). In fact, the clinic-based studies reviewed by Weisz and his colleagues seemed to indicate that the effects of psychotherapy may not be as positive as the findings of the meta-analyses of research-based studies. The authors have provided a number of tentative explanations for the disparity between psychotherapy outcomes in experimental versus clinical settings (see Weisz, Donenberg, Han, & Kauneckis, in press, for a description of these explanations).

Because few of the clinic-based studies were conducted in recent years and because these studies represent a small data base, most of which are dated, definite conclusions about the effectiveness of clinic-based as compared to laboratory-based therapy can not yet be drawn. Thus, future research must concentrate upon expanding the base of research on clinic-based psychotherapy and identifying those conditions under which the positive effects of psychotherapy can best be achieved.

Further, a limited number of studies have been conducted to examine the *specific* treatment approaches that result in beneficial effects for *specific* types of problems. Thus, a second area of needed research is to examine those therapeutic approaches which work most effectively with specific populations of children. A concise summarization of the direction that future research must take has been described by Saxe, Cross, and Silverman (1988) in the following manner: "The important question may not be about the overall effectiveness of child therapy but about the effectiveness of (a) what therapy, (b) under what conditions, (c) for which children, (d) at which developmental level, (e) with which disorder(s), (f) under what environmental conditions, and (g) with which concomitant parental, familial, environmental, or systems interventions" (p. 803).

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Day Treatment Services

According to Stroul and Friedman (1986), day treatment services for children and adolescents are the most intensive form of nonresidential services currently available. "Day treatment" is broadly conceptualized as any program falling in the middle of the continuum of care, that is between inpatient and outpatient treatment (Topp, 1991). The nature of programs defined as day treatment vary widely with regard to setting, population served, intensity, theoretical approach, and treatment components. For example, the settings of day treatment programs vary from hospital-based to school-based and the populations served range from children with severe emotional disorders to children with developmental delays. Theoretical approaches also vary, in that some day treatment programs implement a psychoanalytic approach while others utilize a behavioral approach. Due to this rather broad conceptualization, no universally accepted definition exists.

Stroul and Friedman (1986) defined day treatment as "a service that provides an integrated set of educational, counseling, and family interventions which involve a youngster for at least five hours a day" (p. 44). Through the provision of a broad

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range of services delivered in a coordinated manner, day treatment programs are designed to strengthen individual and family functioning and to prevent more restrictive placement of children (Research and Training Center for Children's Mental Health, 1985-1986). The term partial hospitalization, which refers to those day treatment programs which are hospital-based, has been defined as the "use of a psychiatric hospital setting for less than 24-hour-a-day care" with children returning to their home each night (Tuma, 1989, p. 193). At the other end of the continuum day treatment programs are school-based day programs. Psychoeducational day school programs have been described as "treatment settings for non-mentally retarded children with severe behavior disorders who are unable to function adaptively in the regular school system" (Baenen, Parris Stephens, & Glenwick, 1986, p. 263). Day school programs usually include collaboration between mental health and special education professionals, a multidisciplinary treatment approach, low student-teacher ratios, service provision to families, and the ultimate goal of reintegration into the educational or vocational mainstream.

Although the specific features of day treatment programs vary widely and no universally accepted definition exists, most include the following components (Stroul & Friedman, 1986, p. 44-45):

- Special education, generally in small classes and with a strong emphasis on individualized instruction;
- Counseling, which may include individual and group counseling approaches;
- Family services including family counseling, parent training, brief individual counseling with parents, and assistance with specific tangible needs such as transportation, housing or medical arrangements;
- Vocational training, particularly for adolescents;
- Crisis intervention, not only to assist students through difficult situations but to help them improve their problem solving skills;
- Skill building with an emphasis on interpersonal and problem solving skills and practical skills of everyday life;
- Behavior modification with a focus on promoting success through the use of positive reinforcement procedures; and
- Recreational therapy, art therapy and music therapy, to further aid in the social and emotional development of the youngsters.

Day Treatment Services

Day treatment is unique in that children receive intensive treatment while remaining in their home and community (LeCroy & Ashford, 1992). Day treatment programs serve the dual purpose of acting as an intensive but less restrictive alternative to hospitalization, as well as providing a means of transition for children moving from inpatient to outpatient care (Tuma, 1989). Further, children may receive day treatment services in combination with community-based residential services to increase the impact of both programs (Stroul & Friedman, 1986).

The concept of day treatment is not a new one (Burns & Friedman, 1990). Day treatment for children began in 1943 with the therapeutic nursery school (Grizenko & Papineau, 1992) but has only recently become widespread (Zimet & Farley, 1985). The following sections will provide a review of the recent literature available on the effectiveness of day treatment for children and youth.

Effectiveness and Outcome Research

Two reviews examining the effectiveness of day treatment and day school programs are available (for a description of the research studies contained in these reviews, please see Baenen, Parris Stephens, & Glenwick, 1986; Zimet & Farley, 1985). It should be noted that the rate of reintegration into regular school settings following day treatment has been the most frequently used outcome criterion for evaluating the effectiveness of day treatment programs. Overall, these two reviews revealed that 65-70% of the children in the studies were reintegrated into regular school settings following successful discharge from the day treatment programs. In general, 80% of the children and youth receiving day treatment services improved on clinical measures, while 20% were expelled or sent to a more restrictive setting, such as a residential treatment center (Burns & Friedman, 1990).

In another literature review conducted by Gabel and Finn (1986), the authors stated that conclusive statements regarding the effectiveness of day treatment for children could not be made. However,

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based on the literature reviewed in this article, it appears that many children benefit from day treatment, although treatment gains often are modest. Academic and behavioral improvements were noted in a number of studies and the importance of family involvement during treatment was found to be a critical factor in success.

A more recent review of studies evaluating day treatment programs for children has been conducted by Sayegh and Grizenko (1991). Most of the early studies reviewed in this article were descriptive and clinical in nature and often used a single outcome criterion; therefore, interpretation of effectiveness is difficult. In their review of studies which used rate of reintegration into regular school settings as the single outcome criterion, Sayegh and Grizenko (1991) concluded that day treatment decreases the need for residential placement and thus, reduces cost. They caution that many of the studies contained in the review consisted of a heterogeneous population and therefore, day treatment may not be effective with all populations.

Recent studies have been more successful in examining the effectiveness of day treatment through the use of multiple outcome criteria. In addition to reintegration into regular school settings, these studies have included improvements in the child's behavior and academic performance as outcome criteria. Based on their review of studies using multiple outcome criteria, Sayegh and Grizenko (1991) concluded that although improvement rates for students receiving day treatment services were generally around 67%, most children continued to require long term special educational services following discharge. The authors further concluded that day treatment "is particularly beneficial for children and adolescents with any of the following problems: conduct disorders, attention deficit disorders, adjustment disorders, developmental delays and withdrawn but with normal nonverbal intelligence and severe emotional disturbances. Children referred to day treatment for severe behavior problems often do not improve and tend to drop out of treatment earlier and more often than other children" (Sayegh & Grizenko, 1991, p. 251).

In the following sections, more recent studies (1987 to present) reviewed by Sayegh and Grizenko (1991) will be summarized briefly, as well as additional studies not included in their review. Sack, Mason, and Collins (1987) conducted a

long-term follow-up study of children enrolled in a psychiatric day treatment center which served children with severe emotional disturbances. The program philosophy was basically psychodynamic, psychoeducational and milieu oriented in nature. Each child received a comprehensive assessment and individual treatment plan. Children attended small classes staffed by one milieu therapist and a classroom teacher. Classroom staff were supervised by a multidisciplinary team of professionals. Parents often served as classroom volunteers and received outpatient therapy as well. A total of seventy-nine children were included in this study. A retrospective chart/record review was conducted for each child as well as a semi-structured follow-up interview with a parent, caretaker, or caseworker to obtain information about the child's current adjustment and behavior, family stability, and use of health and mental health services since discharge. Results revealed that children with emotional disorders (anxiety, depression) fared better at follow-up than those children in the broad category of psychotic or behavioral problems. Family stability was also associated with success following discharge. The importance of postdischarge follow-up services and parent involvement during treatment also were noted. The lack of a control group and the use of retrospective chart/record review are limitations inherent in this study.

Cohen et al. have conducted a number of prospective outcome studies evaluating the impact of a therapeutic day treatment program for delayed and disturbed preschoolers (ages 3 to 6 years). These studies have several methodological advantages over other studies, including a prospective design, the use of a control group, the use of standardized measures, and the availability of demographic information (see Sayegh & Grizenko, 1991). In the first study conducted by Cohen, Bradley, and Kolers (1987), a group of 55 children from a therapeutic day care program and 45 children from community day-care centers were included in the sample. Children attended the therapeutic preschool for half days, 5 days/week for a period of 1 to 2 years. Interventions were designed by a clinical team and carried out by classroom teachers in a playroom setting. Treatment goals were based on the individual needs of each child but most often included the establishment of cognitive, language, social, self-help, and language/communication skills; the establishment of limits on disruptive behavior; and assisting the child

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to become a more active participant, to verbally express feelings, and to observe cause-effect relationships. Families were expected to observe and participate in playroom activities under the guidance of staff and to maintain frequent contact with a social worker regarding marital and family issues. To evaluate the effectiveness of the therapeutic preschool program, a battery of objective developmental, behavioral, and clinical measures was administered at three points during the study: initially, eight to nine months later, and at discharge. Results revealed that children with developmental delays and related emotional and behavioral problems made most gains, especially those with nonverbal intelligence in the normal range. Gains were not observed for those children who presented primarily behavioral and emotional problems, except for some improvements in impulse control. Following discharge, forty-two percent (42%) of the children were integrated into regular school settings, however the treatment group did not perform at the level of the control group on psychometric tests. Findings further suggested that intervention for children with developmental delays must be prolonged (up to two years of continuous treatment) and that the period of time required for observable gains depends on the area of functioning being considered and the child's level of development at preadmission.

Cohen, Kolers, and Bradley (1987) conducted a second study of fifty-three children (ages 3 to 6) at the preschool program described previously. The purpose of this study was to identify variables related to treatment outcome in the therapeutic preschool. A battery of measures similar to that of the previous study was administered one month after admission and at discharge. A multiple regression analysis was conducted to examine the relationship between outcome and a number of variables, including initial level of functioning, biological and psychosocial risk indices, age at admission, length of treatment, and degree of parental involvement during treatment. Results indicated that the outcome is most positive for children who function at a relatively high level of development, whose families are motivated, who are younger at admission, and who receive treatment for longer than one year.

Gabel, Finn, and Ahmad (1988) conducted a retrospective study to examine the outcome of a group ($\underline{N}$ = 52)

of predominately African-American children who were severely disturbed served in a hospital-based day treatment program in an urban area. The program served only minority children with severe disturbances from chaotic home environments. The program was mainly psychodynamic in nature with a focus on individual and group psychotherapy. Mental health services were provided by hospital staff, while educational services were delivered by the local school district. Data were collected retrospectively from the records of a children's day hospital over a five year period. Using living arrangement at discharge (home or residential) as the single outcome criterion, the authors found that upon discharge, 56% of the children were recommended for residential placement, while 44% were recommended for continued placement in the home. Variables found to be significantly related to residential placement following discharge included a history of child abuse, parental substance abuse, suicidal behavior, and assaultive/destructive behavior. Day treatment was found to be effective for certain urban, minority children with behavioral difficulties, but less effective if the variables listed above were present at admission. A small sample size, restricted population, the use of retrospective data collection procedures, and the lack of a control group raise important questions about the generalization of these findings to other day treatment settings.

Kosturn, Brown, and Brown (1990) conducted a prospective investigation of the effectiveness of a day treatment program for children with emotional disturbances. The day treatment program accommodated children from age five to twelve years and served only those who exhibited behavior problems both at home and school. Most of the children were classified as having oppositional or conduct disorders. The four major components of the program included day treatment classroom activities, parent training, family therapy, and consultation with school personnel. The program stressed the collaboration of parents, school staff, and therapists in the provision of short-term intensive treatment as an alternative to a more restrictive placement setting. The sample for this study consisted of all children ($N = 75$) admitted to the day treatment program between the years of 1980 and 1985. Complete data were obtained on 23 percent of the original number of participants. Standardized parent ratings of child behavior as

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well as direct classroom observation were used to measure treatment effectiveness. Measures were taken prior to treatment, immediately following discharge, and at three, six, and twelve months following termination. Results indicated that day treatment was associated with significant positive gains as revealed by three standardized parent measures of child behavior. At discharge, parents reported a significant increase in appropriate behavior and a significant decrease in inappropriate behavior as displayed by their child. Further, parental reports indicated that inappropriate behavior was less severe following treatment. Treatment gains were evident at follow-up as revealed by two parent measures administered beyond termination. No significant change in classroom behavior was observed following treatment. This lack of significant change in classroom behavior has been attributed to the fact that behavior was observed only once before and after treatment and that observation periods were of a brief duration (30 minutes). The small number of subjects and the lack of a control group are additional limitations of this study.

Orchard and MacLeod (1990) conducted a two year retrospective review of a day program that served a population of adolescents from 12 to 19 years of age. Program components included group and individual therapy, recreational activities, and life skills and social skills training. In addition, each youth was assigned to a staff person who functioned as a case manager and an in-program therapist. Results for this study were obtained through a review of the records/charts of 97 youth who attended the program over a two year period. Attendance and adjustment to community living were used to measure the success of the program. Using these measures, the day treatment program was determined to be successful in treating this population of troubled youth. The average rate of attendance was 69%. That is, youth attended the day program approximately three out of four days. Additionally, improvement in adjustment to community living was observed at discharge. Approximately 80% of the youth were attending school or work, thus indicating an improvement in community functioning. Further, at discharge almost 77% were living with family or in other community settings, such as group homes or independent living environments. The authors note that these conclusions should be viewed with caution due to the lack of rigorous methodology.

Day Treatment Services

Two additional studies conducted by Grizenko and colleagues examined the effectiveness of a psychodynamically oriented day treatment program for children with behavior problems (Grizenko, Papineau, & Sayegh, 1993; Grizenko & Sayegh, 1990). Children admitted to this day treatment program receive services for an average of seven months. Treatment goals are individually based but often include assisting the child in understanding the cause-effect relationship of family functioning and the child's behavior; allowing the child to express his or her feelings verbally as opposed to behaviorally; building the child's socialization skills, peer relationships, self-esteem and communication skills; and improving academic performance. Program components included special education services, play therapy, social skills group therapy, psychodrama, and group therapy. On a weekly basis, families received family therapy based on a systemic approach. The dispensation of medication was used when deemed necessary. In the earliest study (Grizenko & Sayegh, 1990), the investigators examined twenty-three consecutive admissions to the program using a single group pretest-posttest design. Children and parents were assessed at admission and discharge using standardized instruments to assess behavioral, academic, demographic, personality, and family variables. Discharge scores revealed a significant improvement on all standardized measures for behavior, academics, personality, and family measures. Although all children showed improvement, parents reported greater improvements in behavior than did teachers or therapists. Significantly lower rates in improvement were observed for children with conduct disorder than for those with attention deficit disorder, oppositional defiant disorder, and depression. At admission only 17% of the children were attending regular school, while at discharge 87% of the children had been reintegrated into regular school settings. Findings must be viewed with caution due to a number of methodological flaws inherent in the study, i.e., a small sample size, the lack of long-term follow-up, and the lack of a control group.

In the second study, Grizenko, Papineau, and Sayegh (1993) attempted to correct the methodological flaws inherent in the previous study by including a control group, a larger sample size, and follow-up at six months. The purpose of this study was to evaluate the effectiveness of a multimodal day treatment program

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with a psychodynamic orientation for children with disruptive behavior problems (see Grizenko & Sayegh, 1990, for a description of the program). Thirty children, assigned to day treatment or a waiting list (the control group), were assessed using standardized questionnaires measuring behavioral, self-perception, peer relationships, and family and academic variables. Results revealed that the treatment group showed significantly greater improvements on measures of behavior and self-perception. At six-month follow-up, findings indicated that children in the treatment group had improved over time on all measures except academics. The authors concluded that when compared to a control group, those children receiving day treatment services produced greater gains on the measures, and that these treatment gains were maintained at follow-up.

Cost-Effectiveness

As well as representing a less restrictive component in a system of care, day treatment is a less expensive alternative in comparison to residential services. The cost of day treatment for an individual child typically ranges from $10,000 to $15,000 per year, with funding generally provided by multiple sources such as education and mental health (Stroul & Friedman, 1986). Thus, the relative cost savings of day treatment is evident when compared to residential treatment. A number of studies examining the potential cost-savings of day treatment/partial hospitalization were conducted during the 1970s. These studies consistently demonstrated the cost-effectiveness of partial hospitalization when compared to inpatient treatment (see Parker & Knoll, 1990 for a brief review of these studies).

There is a scarcity of studies, however, comparing the cost-effectiveness of day treatment and hospitalization of children and youth. As a result of our literature search, only two studies were found that focused on the cost-effectiveness of day treatment as compared to residential treatment or hospitalization for youth. The earliest study was conducted by Kiser, Ackerman, and Pruitt (1987) and focused on the relative cost difference of treating children in a day treatment program versus inpatient hospitalization for youth. Findings indicated a significant difference in *daily costs*, with day treatment significantly less than inpatient treatment; however, analyses revealed a shorter length of stay for those receiving inpatient treatment than for those in day treatment.

Thus, *total costs* for day treatment and hospitalization were found not to be significantly different. However, due to the nature of the data collection procedures used in the study, it is likely that the reported lengths of stay for the inpatient group were underestimated and thus, unreliable. Therefore, the authors conservatively concluded that "day treatment is at least as cost effective as hospitalization and may be significantly more cost effective" (Kiser, Ackerman, & Pruitt, 1987, p. 25).

A more recent study conducted by Grizenko and Papineau (1992) compared the cost-effectiveness of day treatment and residential treatment for children with severe behavior problems. In this study, data were gathered through a retrospective chart/record review that examined differences in the cost of treating 23 children admitted to a psychiatric facility for residential treatment and 23 children admitted to the same facility after it was converted to a day treatment program. The two groups were similar across a number of demographic, family, social support, and treatment variables. Two relevant findings emerged: (1) the average length of stay for those in the day treatment program was significantly shorter than for those in the residential program and (2) the total cost of treatment for children in the day treatment group was significantly less than for the inpatient residential group. Although a number of methodological limitations are inherent in this study, the authors stated that issues previously neglected in the literature were explored, thus paving the way for future research endeavors in this area.

Summary and Conclusions

Based on the above literature review, it appears evident that the features of day treatment vary widely. The programs described above represent a wide assortment of treatment settings, populations, treatment approaches, theoretical orientations, and program components. Thus, based on the wide variability among program models, it is not possible to draw conclusive statements regarding the program models of day treatment which are the most effective in promoting behavioral and emotional adjustment. Further, there is a lack of clarity regarding who benefits from day treatment.

Despite this lack of ability to draw firm conclusions, three *tentative* conclusions appear to be suggested in the research contained within this review. First, the

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family plays a significant role in the child's outcomes following day treatment services. A number of studies found that family motivation, family involvement, and family stability during and after treatment were important factors in determining successful outcomes (see Cohen, Kolers, & Bradley, 1987; Gabel & Finn, 1986; Sack, Mason, & Collins, 1987). Secondly, day treatment services may be effective for a limited population of children. That is, most studies found that treatment gains were less likely for children with severe behavior problems than other disability groups (see Cohen, Bradley, & Kolers, 1987; Gabel, Finn, & Ahmad, 1988; Grizenko & Sayegh, 1990; Sack, Mason, & Collins, 1987; Sayegh & Grizenko, 1991). Finally, based on a small number of studies which looked at this variable, evidence seems to suggest that treatment gains have not generalized to the school setting. For instance, Kosturn, Brown, and Brown (1990) found no significant change in classroom behavior following treatment. Also, Grizenko and Sayegh (1990) found that parents reported greater improvements in behavior than did teachers or therapists. Further, the findings of the study conducted by Grizenko, Papineau, and Sayegh (1993) revealed that children receiving services through a multimodal day treatment program had improved on all outcome measures with the exception of academics. Again, these conclusions are tentative and further research is clearly needed.

It should be noted that yet another approach to service delivery which falls under the umbrella of day treatment appears to be emerging. The initiation of interagency systems of care which promote the more effective use of natural settings (i.e., home, school, community) can offer a different perspective of day treatment (Lucille Eber, personal communication, February 14, 1994). At the present time, there are three such programs being sponsored by the U.S. Department of Special Education. One example of such an approach is the WrapAround Project (WRAP) being carried out by the La Grange Area Department of Special Education in Illinois (Eber & Stieper, 1994). Currently, information is available only on the initial phase of the project. The initial phase consisted of a summary of the system's needs assessment which involved the delivery and coordination of wraparound services to 15 youth with emotional and behavioral disabilities and their families. Information gathered from these families led to the proposed systems improvement plan. An 18 month systems planning process was

conducted to create an effective system of support and education for youth with emotional and behavioral disorders and their families. The central feature of this project was the development and implementation of a system design based on the wraparound approach. The wraparound approach entails "wrapping" services and supports around children and their families in natural settings. As a result of the planning process, a number of components emerged which included a school inclusion process, an interagency referral and case coordination structure, the development of noncategorical wraparound supports for children and families, a local and state parent advocacy network, and an interagency focus on the reallocation of resources to promote wraparound service delivery. Although the school-based approach described above has only recently begun to emerge, it appears that the concept of day treatment has broadened to include yet another approach to the delivery of services within the rubric of day treatment.

Despite the wide variability in the features of day treatment programs and the difficulty inherent in trying to make conclusive statements regarding their effectiveness, it appears that day treatment is a promising and cost-effective approach in the treatment of some children and youth with emotional problems. Certainly, further research is needed in this area. Sayegh and Grizenko (1991) stated that future research must focus upon determining the types of children and families that benefit most from this treatment approach, areas of functioning that are most affected by day treatment, and those components of day treatment that are most effective. In addition, studies must utilize more stringent experimental designs, implement more sophisticated statistical analyses, incorporate the use of control groups, establish clearly defined outcome criteria, and utilize standardized assessment instruments (Sayegh & Grizenko, 1991; Zimet & Farley, 1985). Further, more data is needed on comparisons of cost and outcomes for residential treatment and day treatment (Steve Forness, personal communication, January 28, 1994).

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Family Preservation Services

One of the most recently developed approaches in the treatment of children and families is home-based services (Burns & Friedman, 1990), also commonly referred to as family preservation services, in-home services, family-centered services, family-based services, or intensive family services (Anders-Cibik, Zarski, Cleminshaw, & Greenbank, 1990; Cole & Duva, 1990). While a number of both public and private child-serving agencies are involved in the provision of home-based services, most programs share similar characteristics. Based on descriptions set forth in the literature, Stroul and Goldman (1990) have listed the common features of home-based services as follows:

1. The intervention is delivered primarily in the family's home.
2. Home-based services are family-focused, and the family is considered the client.
3. Services have an "ecological" perspective and involve working in collaboration with the community to access and coordinate community supports and services.

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4. Home-based service programs are committed to family preservation and reunification unless there is evidence that the safety of the child is jeopardized.
5. Service delivery hours are flexible in order to meet the needs of the families, and 24-hour crisis intervention services are provided.
6. Home-based services are multifaceted and include counseling, skill training, and assisting the family in obtaining and coordinating needed services, resources, and supports.
7. Services vary along a continuum of intensity and duration based upon the goals of the program and needs of the family.
8. Staff have small caseloads (2 to 3 families) which permit them to work in an active and intense manner with each family.
9. The relationship between the home-based worker and the family is uniquely close, intense, and personal.
10. Home-based programs are committed to empowering families, instilling hope in families, and assisting families in setting and achieving personal goals and priorities.

As noted above, home-based services may vary with regard to service intensity and duration. Family preservation services represent one type of service under the rubric of home-based services. Family preservation services are defined as "short term, in-home, intensive, crisis intervention services" having an ecological perspective and a family-based focus (Yelton, 1991, p. 7). Thus, family preservation services tend to be of short duration (ranging from 1 to 3 months), but are highly intensive (10 to 20 or more hours per week). Services are provided to families in which a child is at imminent risk for placement in a more restrictive setting due to child abuse, neglect, juvenile delinquency, status offenses, emotional problems, or school difficulties (Forsythe, 1992) and usually are rendered only when other interventions have proven unsuccessful (Cole & Duva, 1990). Most family preservation services have three primary goals: (1) to preserve the integrity of the family and to prevent the unnecessary placement of children in substitute care while simultaneously ensuring the safety of the child; (2) to develop an ongoing community support system by linking the family with appropriate community agencies and individuals; and (3) to increase the coping skills of the family and its capacity to function effectively in the community (Stroul

& Goldman, 1990). In addition, family preservation services are used to assist children already in placements to reunify with their families (Anders-Cibik, Zarski, Cleminshaw, & Greenbank, 1990; Stroul & Goldman, 1990). The Child Welfare League of America (1989) has established a set of standards for the delivery of family preservation services. These standards for services provide a thorough description of the goals of family preservation programs which are designed to strengthen and preserve families with children.

There has been a significant increase in the number of family preservation programs over the past decade (National Resource Center on Family-Based Services, 1991). This growth has been attributed to a number of factors:

1 the increasing number of children in out-of-home placements and dissatisfaction with these placements, especially foster care;

2 an increased focus on family integrity and the importance of the parent-child relationship;

3 the move towards an ecological perspective in the provision of treatment rather than a personalistic perspective;

4 the establishment of public policy mandates (e.g., Adoption Assistance and Child Welfare Act of 1980) that strive to preserve families; and

5 the search for less expensive alternatives to care (Whittaker & Tracy, 1990).

Funding/ Cost/Cost-Effectiveness

Until the passage of the Omnibus Budget Reconciliation Act of 1993 (H.R. 2264), there was no federal funding stream specifically targeted for family preservation programs (Cole & Duva, 1990). This Act, signed into law in August of 1993, provided new federal funding for family preservation services. Over a 5 year period, one billion dollars in child welfare funds will be provided to states for a variety of early intervention and prevention services with the intent of strengthening, preserving, supporting, and/or reunifying troubled and at-risk children and their families. In the past, most states have re-directed funds to implement pilot projects or family preservation services on a statewide basis. A descriptive study of community-based services for children and adolescents with severe emotional disturbances found that state government represented the major funding source for the provision of home-

based programs, while the state mental health department represented the second most frequent source of funding (Stroul & Goldman, 1990). The practice of shared financing among various child-serving agencies represents yet another commonly used funding approach. Family preservation services increasingly are being funded through collaborations among departments of mental health, child welfare, and at times, juvenile justice (Knitzer & Yelton, 1990).

The reported costs of providing home-based services vary widely due to differences in intensity and duration of programs, variations in staffing patterns and salaries, and differences in accounting and costing approaches (Hutchinson cited in Stroul & Goldman, 1990). In a comparison of home-based services and out-of-home placements, Polsky (1986) estimated the cost of home-based services as ranging from $3,000 to $5,000 *per episode*, while the cost *per year* of foster care was reported at $5,000, group homes at $10,000, detention at $20,000, residential treatment centers at $30,000, and psychiatric hospitalization at $40,000. Further, costs differentials are substantially greater when one considers that children are often in out-of-home placements for more than one year.

Kinney, Haapala, and Booth (1991) reported the cost-effectiveness of the Homebuilders model of family preservation for sites in Washington State and the Bronx. During 1989 in Washington State, the cost of Homebuilders averaged $2,700 per child for those deemed appropriate for placement. A comparison of the difference between the cost of Homebuilders and various out-of-home placements in Washington State illustrated the cost savings. For example, the total cost of Homebuilders for 60 children was $162,200/year ($2,700/child); however, the cost of foster care for the same number of children was estimated to be $468,780/year ($7,813/child). When compared to other more restrictive placements, such as residential treatment centers and psychiatric hospitalization, the use of family preservation services resulted in substantially greater cost savings. An analysis of the initial results of the Bronx Project revealed that the cost for Homebuilders services for the first 6 months was $211,892 for all children. This estimated cost is $2,306,048 *less* than the average cost of out-of-home placement for the same number of children.

An examination of the cost-effectiveness of the Families First program in

Michigan as compared to traditional foster care services was conducted over a 6-month evaluation period (Michigan Dept. of Social Services, 1993). Of the 626 families referred to Families First during this 6 month period, 96% of the families were deemed as having children at risk of out-of-home placement by child protective service workers. Assuming that this estimate was correct, the prevention of foster care placement for 96% of the children referred to Families First over the program's 3-year period (n = 6,656) could have saved the state more than $55,000,000 for the first year following the family preservation intervention. It should be noted that due to the low cost of the Families First program, cost savings would remain substantial even if a more conservative estimate of the percentage of children at-risk for placement was used.

A financial analysis also was conducted to determine the financial savings achieved through utilization of the Family Ties program operated by the New York City Department of Juvenile Justice (New York City Department of Juvenile Justice, 1993). The average cost for placement in the New York State Division for Youth facility is about $70,000/year/child. This cost is distributed equally between the City of New York and the State of New York. The Family Ties program achieved a total savings of $11,043,318 in placement costs from FY 1989 through the first half of FY 1992. Thus, the savings to New York City was over $5,500,000. The cost-effectiveness of family preservation and family reunification services has been supported in other studies as well (see Berry, 1992; Henggeler, Melton, & Smith, 1992; Woodworth, Hyde, Jordan, & Burchard, 1994). On the basis of these and other studies, it appears that family preservation services are cost-effective in relation to out-of-home placements, especially residential placement settings.

According to Wells (personal communication, February 8, 1994), methodologies used to determine the cost-effectiveness of family preservation services are fraught with difficulties and must be viewed with caution. For example, most cost determinations do not include the cost of follow-up services that accompany family preservation services. To be relevant, all related services used by families during treatment and following service termination must be considered.

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Effectiveness and Outcome Research

Family Preservation Services

The developers of family preservation services have led the way in conducting research to evaluate the effectiveness of this approach. Early evaluations of family preservation services revealed generally positive results; however, these investigations have been criticized for using a single outcome criterion (i.e., the avoidance of out-of-home placement), small sample sizes, and methodological flaws (see Hinckley & Ellis, 1985; Kinney, Madsen, Fleming, & Haapala, 1977). Recent studies have attempted to address these criticisms by examining multiple treatment outcomes, exploring correlates of treatment success and failure, and employing experimental and quasi-experimental research designs (Wells & Biegel, 1991). The most frequently cited literature examining the effectiveness of family preservation services is summarized in the following pages.

Homebuilders

The Homebuilders program, established in 1974 in Tacoma, Washington, is perhaps the best known of the family preservation programs and has served as a model for the establishment of several similar programs across the country. Early reports of the Homebuilders program indicated a success rate of greater than 90%; that is, less than 10% of the children who received family preservation services were placed outside the home (Kinney, Madsen, Fleming, & Haapala, 1977).

Haapala and Kinney (1988) reported the success of a Homebuilders program designed to avert out-of-home placement for status-offending youth who were at risk for foster care or residential placement. Participants in the study were 678 status-offending youth referred to Homebuilders. Youth and their families received family preservation services from one of four Homebuilders programs in Washington State. Placement prevention rates were gathered for youth at 12 months following intake into the Homebuilders program. Of the 678 youth receiving services, 592 (87%) avoided out-of-home placement during the 12-month follow-up period. The remaining youth were placed in foster, group, or residential care. Although the results of this study are promising, findings must be viewed with caution due to the lack of a comparison group and the possible effects of additional counseling services received by

the families following termination from the Homebuilders program.

A major study was conducted by Fraser, Pecora, and Haapala (1988) to evaluate the Homebuilders program and to compare it to a similar program in Utah. This study examined the initial outcomes for 453 families and included a 12-month follow-up for 263 families. Overall, greater than 70% of the families remained intact at service termination. At one year follow-up, approximately 66% of the Homebuilders families and over 56% of the Utah families remained intact. Those families that remained together also received improved ratings on a variety of measures, including school adjustment, delinquent behavior, behavior at home, parenting and supervision of children, parental knowledge about child care, and parental attitudes toward placement.

Pecora, Fraser, and Haapala (1991, 1992) examined six intensive family preservation programs and collected pretest-posttest data from families receiving family preservation services in Utah (2 sites) and Washington State (4 sites). For the families in Utah, almost 91% remained intact and for families in Washington State, the rate was almost 94% at case termination. Thus, on the average, 93% of the at-risk children who received intensive family preservation services remained with their families or relatives at termination. A total of 4 children were placed with relatives at or before termination of services. When placement with relatives was considered a service failure, the treatment success rate was 92.3% for children at all sites. For the cases in Utah, the rate was 89.5% and for Washington cases, 93.4%.

Placement prevention rates for the 12-month follow-up group (n = 263 families) indicated that treatment gains had declined over time. That is, 67% of the 342 children who were followed for 12 months after receiving family preservation services remained with their families or relatives throughout the year. The placement rates of a small comparison group, (26 Utah families that had been referred for family preservation services, but instead received traditional services) were compared to those in the treatment group. The out-of-home placement rate was higher for those in the comparison group (traditional services) than for those in the treatment group (family preservation services). Out-of-home placement rates for the comparison group were almost twice that of the treatment group when compared at 12 months (85% and 44% respectively).

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In addition, a more stringent analysis was conducted to compare the treatment success of the Utah comparison group cases and a matched set of cases who received intensive family preservation services. Cases in the comparison group and the experimental group were matched on the following characteristics: the child's race, gender, school attendance, suspected or substantiated substance abuse, handicap status, and previous inpatient treatment history as well as family income, family structure, and size of household. For the subset of matched treatment cases receiving intensive family preservation services, the placement rate was 44%. This rate was significantly lower than the placement rate for comparison group cases (85%).

In 1987, a Homebuilders program was established in Bronx, New York. The program served children who were abused and neglected. Data collected from May 1987 through August 1988 represented 58 families with 101 children at risk of placement. Approximately 13% of the children were in "official placement" three months after termination of Homebuilders services (Kinney, Haapala, & Booth, 1991); that is, placement settings such as foster care, group care, residential treatment, or hospitalization as opposed to placement with relatives.

Hennepin County, Minnesota

The Center for the Study of Youth Policy at the University of Minnesota conducted an evaluation of a family preservation pilot program established in 1985 (AuClaire & Schwartz, 1986; Schwartz, AuClaire, & Harris, 1991). Families were deemed eligible for participation in the study if they had been approved previously for a home-based placement by both a supervisor and a program manager. A comparison group (n = 58) was comprised of a randomly selected sample of adolescents who were eligible to receive home-based services but could not be served due to the full capacity of the pilot program. The use of all residential placements by subjects was documented over a 12- to 16-month period. Results revealed that youth receiving family preservation services (n = 55) experienced fewer out-of-home placements (56%) then those in the comparison group (91%). *However, the groups did not differ significantly with regard to the incidence of placement when out-of-home placements such as living with extended family or friends was included.* Those in the treatment group experienced fewer days in placement (2,368) in comparison to those in the control group (3,803). The two groups did

not differ in the average number of placements; however, those receiving home-based services were placed in less restrictive settings.

Maryland

Pearson, Masnyk, and King (1987) conducted a preliminary evaluation of the Intensive Family Services pilot project in Maryland. Evaluation data from 1984 revealed that only 10% of the families receiving services experienced a placement. Further, those counties in which the Intensive Family Services project was implemented experienced a substantially greater decline in the use of foster care than counties in which such services were not available. A more extensive study conducted the following year found that families receiving intensive family services experienced fewer placements and had significantly lower scores on measures of risk to the child as compared to families who received traditional services.

California

In 1984 the California legislature authorized a bill to fund eight intensive home-based service projects with the purpose of preventing foster care placement and lowering the subsequent abuse or neglect of children under the age of fourteen. A 3-year study was conducted by Walter McDonald Associates to evaluate the effectiveness of these programs (see McDonald and Associates, 1990; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990). During the third year of the projects, an investigation was carried out which examined the functioning of families with one or more children at risk of out-of-home placement. More specifically, the study compared the number of placements for families receiving services from five intensive family preservation service projects across California (the treatment group) to a group of families receiving traditional services (the control group). Families were randomly assigned to either the treatment condition (n = 152) or the control condition (n = 152). Placement data were obtained from time of referral to 8 months following the referral. Results led to the following six conclusions:

1. no significant differences were found in the proportions of treatment and control families that experienced a placement;
2. no significant differences were observed in the number of treatment and control families who were investigated for abuse and/or neglect following their inclusion in the study;

3. no significant differences were observed between the treatment and control groups in the number of days spent in placement;
4. significant differences were found between the treatment and control groups in the number of children placed within two months of referral;
5. children in the treatment and control groups experienced an equal number of placement incidents; and
6. placement days with relatives and foster families "accounted for 91.2 percent of all placement days and 81.9 percent of all placement days and 72.8 percent of [all] of the [placed] children in the . . . experimental group" (McDonald & Associates, 1990, p. 617).

A number of problems, such as high staff turnover rate and difficulty getting referrals from child protective services, were experienced throughout the 3-year project. The evaluation report provides extensive explanations of the difficulties experienced by the project sites (see Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990).

New Jersey

Using an experimental design, Feldman (1991) evaluated the effectiveness of five intensive family preservation programs. Families deemed eligible to receive family preservation services were randomly assigned to either the experimental group (family preservation services, $n = 96$) or the control group (traditional services, $n = 87$) in one of four New Jersey counties. Data were collected on out-of-home placement, family functioning, and family characteristics for up to one year following service termination. Results revealed that early in the treatment program (from 1 to 9 months) significantly fewer children in the treatment group experienced out-of-home placements; however, these differences in placement rates dissipated by the twelfth month of treatment. Further, families in the treatment condition generally failed to improve on measures of family functioning as compared to those in the control condition.

Iowa

Thieman and Dall (1992) reported the results of the evaluation of a statewide family preservation program in Iowa, modeled after Homebuilders. The purposes of the study were to assess changes in family functioning through a pretest-posttest assessment as measured by the Family Risk Scales (see Magura, Moses, & Jones, 1987) and to examine the validity of these scales as a predictor of risk for foster care placement. At the time of publication, data had been

collected on approximately 1,500 families. Data collection was limited to families who had been served during 1990-1991, resulting in a total of 995 families. Assessment of the child's risk for out-of-home placement was obtained using the Family Risk Scales. Risk for out-of-home placement was based on three factors: parent-centered risk, child-centered risk, and economic risk. Pretest scores were used to divide the families into categories of higher risk (Group 1) or lower risk (Group 2) for out-of-home placement. Results indicated that the instrument was not useful in predicting out-of-home placement of children at service termination and failed to identify the acute risk characteristics of families referred for family preservation services. Results did indicate modest, but statistically significant, increases in family functioning from initiation to termination of service for both higher and lower risk groups as measured by the scales; however, change was most evident for those in the higher risk group, Group 1. An uncertainty regarding the effectiveness of the instrument in predicting out-of-home placement risk and the lack of a comparison group are limitations inherent within this study. Evaluation activities that address these limitations currently are underway.

Northern California

Berry (1992) conducted an evaluation of the In-Home Family Care Program, an intensive family preservation program in Northern California. Over a 3- year period, data were collected for a total of 367 cases. Measures included case outcomes, client characteristics, and service characteristics. Results revealed that only 4% of the families experienced a placement while receiving family preservation services. Six percent experienced out-of-home placements within 6 months after services were terminated, and 12% of the families experienced a placement at one-year follow-up. Thus, out-of-home placements were avoided in 88% of the families served by this program. The type of service provided was found to have an effect on treatment outcome. That is, concrete services such as teaching family care skills, supplemental parenting, medical care, financial services, and assistance in obtaining food were found to be associated with parents who improved their parenting skills and families that remained together following termination from the program. It appears that this program was effective at preventing foster care placement as well as initiating lasting improvements in family functioning

through the provision of concrete services. Further studies are currently underway to examine the re-occurrence of abuse charges upon termination of services.

Texas

Leben and Smith (1992) reported the results of two intensive family intervention projects in Texas. Findings were based on data for 109 youth and families who received intensive family intervention services from August 1989 through April 1991. These two project sites served adolescents with emotional disturbances who either were returning from an out-of-home placement or were at risk for removal from the family setting. Results indicated that the program was successful in avoiding an out-of-home placement during treatment for about 79% of all children. At the end of the project, about 62% of the youth had remained in the home and had not experienced an out-of-home placement. Using a 5-point rating scale, therapists or program directors rated improvement in functioning as compared to initial intake impressions. Almost 25% of the adolescents were rated by their therapists as functioning *much better*, while 33% were rated as *better*. The remaining adolescents were rated as the *same*, *worse*, or *much worse* at the closing of the case. Using the same rating system, therapists rated improvement in parents' functioning following service termination. About 20% of the families were rated as functioning *much better* and about 35% were rated as functioning *better*. Follow-up information indicated that 62% of the adolescents were still living at home. Almost 60% of the families finished the "full term" of treatment and 75% who were referred for additional outpatient counseling went at least once following termination from the program. Thus, it appears that the program was successful in avoiding out-of-home placements for the majority of adolescents in the study; however, placement avoidance rates had decreased by the end of the project. Further, greater than half of the adolescents and families were rated by the therapists as functioning *much better* or *better* at case termination. The findings of this study are limited due to the use of a descriptive and formative design; however, a more comprehensive program evaluation currently is underway.

South Carolina

Henggeler, Melton, and Smith (1992) conducted a study to examine the efficacy of a family preservation program using multisystemic family therapy (MST) in decreasing the rates of institutionalization

of youthful offenders and in reducing antisocial behavior. Eighty-four juvenile offenders, judged to be at risk for out-of-home placement, participated in the study. Results revealed that at 59 weeks post-referral, youth who had received family preservation services using multisystemic treatment had approximately half as many arrests as youth who received traditional services. Recidivism rates (rates of re-arrest) were 42% for the treatment group and 62% for the comparison group. Further, results revealed that a composite measure of family cohesion indicated that families participating in the family preservation program experienced greater cohesion, while families receiving traditional services experienced decreased cohesion. A composite measure of aggression toward peers revealed that those youth in the treatment condition had a decreased level of aggression, while those in the control condition experienced no change in aggression as a result of treatment. These findings support the efficacy of a family preservation program using multisystemic therapy in reducing out-of-home placements and in decreasing criminal activity as compared to traditional service delivery methods.

Through a search of archival data, long-term, follow-up data on re-arrest for the above sample ($N = 84$) were gathered for an average of 2.4 years post-referral (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). Results revealed that multisystemic family preservation was more effective than traditional services in prolonging the time to re-arrest for this sample. The mean time to re-arrest for those receiving multisystemic family preservation services was about 56 weeks, while the mean time to re-arrest for those receiving traditional services was about 32 weeks. At 2.4 years (120 weeks) post-referral, 39% of those in the multisystemic family preservation group had not been re-arrested, while 20% of those receiving traditional services had not been re-arrested.

Other controlled clinical studies examining the effectiveness of family preservation using multisystemic treatment with adolescents having substance abuse and serious criminal behavior have been conducted (see Henggeler et al., 1994, for a brief review of these studies). Findings from the *Missouri Delinquency Project* represent the most comprehensive and extensive evaluation of family preservation using MST. Chronic juvenile offenders ($N = 200$) were randomly assigned to either a group who received MST or a group who received individual therapy. In addition to

recidivism data for 4 years following treatment, pretest-posttest self-report and observational measures were collected to assess individual, peer, and family functioning. Observational measures revealed that families who received MST exhibited more supportiveness and less conflict/hostility in mother-adolescent, father-adolescent, and mother-father relations as compared to those families in the individual therapy condition. Those in the MST condition also reported more family cohesion and adaptability. Adolescents in the MST group displayed significantly fewer behavior problems following treatment and parents reported less symptomatology. Four-year follow-up data indicated that recidivism rates were 22% (MST group) and 71% (individual therapy) for those who completed therapy. Of these recidivists, those in the MST condition were arrested less often and for less serious crimes than those in the comparison group.

Another randomized, controlled study examining the effectiveness of family preservation using MST was conducted in Charleston, South Carolina. Adolescents (N = 112) exhibiting both substance abuse and delinquency problems were randomly assigned to either the MST condition or the usual services condition. A battery of assessment devices were administered at pretreatment, posttreatment, and at 6- and 12-month follow-up periods. Preliminary results from 20 cases revealed that the MST group experienced more gains in abstinence from substance abuse and delinquency resulting in decreased institutionalization as compared to the usual services group (Henggler et al., 1994).

Michigan

In response to increased public concern over a statewide increase in cases of child abuse, neglect, and delinquency, the Michigan Department of Social Services (MDSS) created a family preservation program, Families First, designed to serve as an alternative to traditional child protective service approaches such as foster care. The program provided a range of support services on an intensive, short-term basis to families in crisis.

An evaluation (Michigan Department of Social Services, 1993) was conducted to determine the program's effectiveness in comparison to foster care services in averting children from out-of-home placements. The evaluation involved a group of children (n = 225) who received family preservation services through the Families First Program and a matched group of children (n = 225) who received traditional foster care services.

The study covered a 3-year period and utilized multiple data sources. In an examination of out-of-home placement rates for the two groups, results revealed that children in the Families First program evidenced a consistently lower out-of-home placement rate at 3, 6, and 12 months following the intervention. At 3-month follow-up, out-of-home placement rates were 7% for the Families First group and 15% for the foster care group. Six-month follow-up data revealed out-of-home placement rates of 12% for the Families First group and 26% for the foster care group. Out-of-home placement rates at 12-month follow-up were 24% for children in the Families First group and 35% for those in foster care. Even more striking differences were noted in out-of-home placement rates for the two groups when 39 pairs of children referred due to delinquency and reunification were removed from the analysis. For the matched pairs of children (N = 186 pairs) referred due to abuse and/or neglect, respective out-of-home placement rates at 3, 6, and 12 months were 5%, 13%, and 19% for the children in the Families First group and 12%, 26%, and 36% for children who received foster care services.

City of New York

The New York City Department of Juvenile Justice was the first juvenile justice agency in the nation to implement a placement diversion program (Family Ties) based on the Homebuilders model of family preservation (Collier & Hill, 1993). The primary objective of the program was to prevent the unnecessary placement of adjudicated juvenile delinquents by directly intervening in the youth's life and assisting with problem areas that contributed to the delinquency.

A quasi-experimental design was employed to measure outcome differences between youth in the Family Ties program and a group of juveniles not served by the program. Primary outcome measures included rates of re-arrest, re-conviction, and re-incarceration for the year following release from the Family Ties program or, for those in the comparison group, from the state youth facility. Positive behavior changes exhibited by program youths also were used to assess outcome. Former program youth (n = 93) were randomly selected for inclusion in the study. Of that number, 57% (n = 40 families) consented to an interview. The comparison group was comprised of randomly selected juvenile delinquents (n = 40) who were

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adjudicated in Family Court and placed in a state youth facility. Groups were found to be comparable in background and at-risk variables and had been in the community about the same length of time (1 year) before follow-up.

Results indicated that the program was able to avert from placement an average of 65% of the youth received through court referrals. This placement-aversion rate falls within the normative range for similar family preservation programs. For youth and families participating in the program during 1991-92, six month data indicated that approximately 8 in 10 youth remained uninvolved with the juvenile justice system. No significant difference was noted between 6- and 12-month follow-up. Rates of re-involvement were significantly lower for those in the Family Ties program than for the comparison group. For those in the program, the rate of re-arrest was 20%, while re-conviction and re-incarceration rates were each 18%. For the comparison group, the rate of re-arrest was 42% and the rates of re-conviction and re-incarceration were 40% each. As another measure of outcome, the evaluation focused on the amount of placement time saved as a result of the Family Ties program. On average, in 1992, the program averted almost 6 weeks of placement time during the program and nearly 10 months following participation in the program. For results on the program's model and process, please refer to Collier and Hill (1993).

In a study designed to examine child and family functioning following intensive family preservation services, Wells and Whittington (1993) sought to answer two important questions: (1) how well were families who had received family preservation services functioning at follow-up and (2) did family functioning improve between admission and discharge and, if so, was improvement maintained at follow-up. A sample of 42 families was included in the analyses. A family was eligible to participate in the study if it had a child between the ages of 10 and 18 years who had been referred to the family preservation program. Data were collected from children, parents, and caseworkers at admission, discharge, and one year following service termination.

Sources of data included measures of family and child functioning, the resolution of problems reported at admission, and stability of the child's living situation between discharge and follow-up. Family and child functioning, as measured by three standardized instruments, was defined in terms of the promotion of family health, the

elimination or reduction of parent-child conflict, and the amelioration of child behavioral problems. The resolution of admission problems was defined as the degree to which the problems reported by parents and children at admission had improved and the proportion of these problems that had been eliminated by discharge or follow-up as measured by self-report. The stability of a child's living situation between discharge and follow-up was defined as the extent to which the child remained in the home he or she was in at discharge or was scheduled to return to at discharge. The stability measure reflected the number of changes in placement between discharge and follow-up.

Results revealed that, on average, families were functioning at a lower level than the nonclinical samples of families at follow-up. Both children and parents reported the health of their families and their relationship with each other as less adequate and children's behavioral problems as more severe than when compared to nonclinical samples. Children's behaviors and parent-child relationships were evaluated in a more negative manner by parents than by children. Evaluations of family health were similar for both parents and children.

With regard to the resolution of admission problems, parents and children reported that many of the problems apparent at admission were resolved or had improved at follow-up. On average, children stated that more than 50% of the problems they had reported at admission were eliminated or resolved, and for those problems still present, children reported modest improvement since discharge. At follow-up, parents reported, on average, that more than one-third of the problems reported at admission were eliminated or resolved. Parents reported modest improvement for those problems still present.

During the follow-up period, measures of stability indicated that the majority of children (59%) remained in the home in which they had lived at discharge. Of those who did experience placement changes, the highest percentage (47%) moved only once, 41% experienced from two to four placement changes, and the remainder (12%) experienced eight or nine moves. Results of the use of out-of-home placements between discharge and follow-up indicated that 80% of the children used no out-of-home placements, while the remaining children were placed in psychiatric hospitals, group homes, correctional facilities, residential treatment

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centers, foster homes, or child-care institutions.

In the examination of improvements in child and family functioning over time, results revealed that, on average, the functioning of children and families improved between admission and discharge and did not decline between discharge and follow-up. A statistically significant difference was noted in children's average scores from admission (2.50) to discharge (2.30) to follow-up (2.28) as measured by the Family Assessment Devise-Version 3 (Epstein, Baldwin, & Bishop, 1983). Scores decreased from admission to discharge, but remained essentially the same from discharge to follow-up. Scores on the Child Behavior Checklist (Achenbach & Edelbrock, 1983a) and Youth Self-Report Form (Achenbach & Edelbrock, 1983b) were found to be statistically different over time, with a mean score of 73.15 at admission, 69.73 at discharge, and 62.44 at follow-up. Further, no significant difference was noted between discharge and follow-up in change in admission problems as the level of improvement at discharge was maintained at follow-up.

Family Reunification Services

Utah

Rather than focusing on the use of family preservation as a way of preventing out-of-home placements, Walton, Fraser, Lewis, Pecora, and Walton (1993) examined the effectiveness of family preservation services in reunifying children with their families. This study, conducted in Utah, utilized a posttest-only experimental design. Families were randomly selected from a computer-generated list of children in out-of-home care. The sample was randomly assigned to either the treatment or control group. The treatment condition was comprised of a group of families (n = 57) who received family preservation services, while those in the control condition consisted of families (n = 53) who received traditional family foster care reunification services. Data were collected at the beginning and end of the 3-month treatment period. Findings revealed that at the end of the 90-day treatment period, 93% of the families in the treatment condition were reunited as compared to only 28% of the families in the control condition. Six-month data revealed that some of the children in the treatment group who had been reunited with their families had returned to an out-of-home placement, while more of the

children in the control group had returned to their homes. Of the 53 children in the treatment group who were living at home at the end of the treatment period, 40 (70% of the total treatment group) remained in the home 6 months later. During this time, an additional 7 children in the control group returned home, resulting in a total of 22 (41.5%). Data collected at 12 months after the termination of services revealed that 43 (75.4%) of the children in the treatment group were in their homes as compared to 26 (49%) of the children in the control group. Further, those receiving family preservation services spent significantly more days living at home during the 90-day treatment period and follow-up periods than those receiving traditional services.

New England

Fein and Staff (1993) reported the findings from the first 2 years of a 3-year demonstration project in New England. In 1989, Casey Family Services, a private child welfare agency, expanded its services to include three reunification programs located in Connecticut, Maine, and Vermont. These reunification programs were designed to serve children placed in state family or group foster care due to abuse or neglect and who had a permanency plan which called for reunification with the biological family.

During the first 2 years of the demonstration project, 110 children (47 families) were served by the program. Children ($N = 68$) who had received services for 6 or more months were the focus of the current analyses. During the first 2 years, 26 of the children (38%) had been reunited with their biological families. Of those children, 13 (19%) were at home and still receiving services, 6 (9%) were at home and their case had been closed, and 7 (10%) were returned to out-of-home care. Thus, a total of 19 (28%) children remained reunified with their families by the end of the second year of the project.

Baltimore, Maryland

Woodworth, Hyde, Jordan, and Burchard (1994) presented the findings of two initial studies of the Family Preservation Initiative of Baltimore City, Inc. (FPI) founded in January 1991. Based on a wraparound care model approach for the provision of family reunification services, this initiative was designed to return children from out-of-state placements, divert inappropriate out-of-home and out-of-state placements, and redirect funding streams from out-of-home placements to community-based placements.

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Study 1 examined the effectiveness of FPI services and the use of the principles of wraparound by evaluating the outcomes of youth returned and diverted from out-of-home placements. Participants in the study included all youth returned and diverted from out-of-state care by July 1, 1993. Information was gathered about each youth's history and placement changes. Updated information was collected on a monthly basis. The Restrictiveness of Living Environments Scale (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992) was used to provide an index of the restrictiveness level of residential placements. Data on adjustment behaviors (school suspensions, psychiatric hospitalizations, attempted suicides, and delinquent arrests) were gathered to monitor the progress of the youth.

Prior to entering FPI service, 20% of the youth were in placements having a restrictiveness level of 5.5 (group home level care) or less. At the end of FY 1993, the percentage of youth having a restrictive level of 5.5 or less had risen to 82%. With regard to the number of residential placements while in FPI care, the majority of youth (65%) had only one placement, 30% had two to four placements, and 5% had five to seven placements. In terms of school placement, 65% had only one placement, 26% had two placements, and 19% had three placements. The following results were obtained for the occurrence of adjustment behaviors: 30% exhibited none of the behaviors, 29% experienced school suspensions, 21% experienced psychiatric hospitalizations, 6% attempted suicide, and 14% experienced delinquent arrests. Parent and youth satisfaction measures of services and programs were obtained by phone. On a scale of 1 (very dissatisfied) to 5 (very satisfied), parents reported an overall mean rating of 3.5 on measures of satisfaction with services, while youth reported an overall mean rating of 3.9. With regard to satisfaction with various program components, parents had an overall mean rating of 3.8 and youth had an overall mean score of 3.5.

Study 2 examined the effectiveness of FPI's services specifically for youth returned from out-of-state placement. Data were gathered for a sample of youth ($N = 30$) who had been returned from out-of-state placement and who had received FPI services for at least 6 months. Results suggested that FPI's methods of returning youth from out-of-state placements assisted them in maintaining less restrictive placements than before out-of-state placement. Those who returned from out-

of-state placements revealed a decrease in both level of restrictiveness and number of placements. Further, psychiatric hospitalization was found to be the best predictor of level of restrictiveness following out-of-state placement. That is, youth with a greater number of psychiatric hospitalizations upon return from out-of-state placements were more likely to be placed in more restrictive environments. However, length of out-of-state placement was not found to be related to higher levels of restrictiveness upon return to the state. A second analysis revealed that youth in more restrictive placements prior to leaving the state spent a longer amount of time in out-of-state placements.

Conclusions and Future Research Needs

Based on the studies included in this review, it appears that family preservation services have been effective in averting the placement of a high percentage of children. At service termination, the percentage of children remaining with their families ranged from about 70% to 96% (see Table 1). Most studies, however, did not utilize a control or comparison group. The percentage of children averted from placement tended to decrease at follow-up. However, percentages were greater for those receiving family preservation services at follow-up than for those in comparison or control groups. Few studies have been conducted that examined outcome measures other than placement prevention rates. Of the 18 studies reviewed, only two explored the effects of family preservation services on child or family functioning. Thieman and Dall (1992) found a statistically significant increase in family functioning from admission to termination for those receiving family preservation services. Wells and Whittington (1993) found that family functioning improved between admission and discharge, with no decline apparent between discharge and follow-up. Many of the problems present at admission had been resolved or had improved. Almost 60% of the children had remained in the home in which they lived at discharge.

Similar trends were apparent in the studies which examined the use of family preservation services for the purpose of reunifying families; that is, reuniting children already in out-of-home placements with their families. While the percentage of children reunified was greater for those in the treatment as compared to the control groups, those percentages decreased as the

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amount of time from discharge increased. In an examination of outcomes other than rate of placement prevention, Woodworth, Hyde, Jordan, and Burchard (1994) found that restrictiveness of placements was less during the period following 6 months of family preservation services than the period prior to out-of-state placement.

While it appears that many family preservation programs have proven effective in keeping families intact and preventing or delaying the placement of children deemed at-risk for substitute care, the effects do not appear to be long lasting, and families continue to be at-risk following service termination. That is, it seems that treatment gains appear to decrease as the amount of time following discharge increases. In an examination of factors related to successful adaptation following the termination of services, Wells and Whittington (1993) found that child and family factors (risk of child removal at admission and formal and informal support of parent following discharge) were more strongly related to family functioning at follow-up than were treatment factors (engagement in treatment and resolution of admission problems at discharge). Further, families with a child at imminent risk of removal at admission were found to be less likely to engage in treatment and less likely to have a high level of family health at follow-up than those with children at lower risk for out-of-home placement.

In a review of the major evaluations of family preservation programs, Rossi (1992) concluded that in spite of the fact that the majority of evaluations involved randomized experiments or close approximations to such designs, definitive findings concerning effectiveness can not yet be ascertained. Small sample sizes and the use of overly simplified analyses strategies commonly were noted as problem areas in evaluations included in the review. Further, the majority of studies currently available have used a single outcome criteria, i.e., rate of placement prevention. A number of evaluators have criticized the use of placement prevention rates as the single criterion to determine the effectiveness of family preservation services (Rossi, 1992). In fact, it has been argued that placement "is an ambiguous indicator of treatment failure. Placement may be a positive outcome for some children. It may be affected by factors unrelated to the functioning of a family or a child, such as the availability of placement resources in a community. Moreover, research has shown that the majority of children admitted to intensive family preservation programs would *not* [italics added] have been placed

without the program. Thus, it is difficult to use absence of placement as an indicator of success" (Wells & Whittington, 1993, p. 57). In addition to placement prevention rates, research endeavors must include other criteria, such as the stability of the child's living situation, the quality of the child's living situation (Wells & Whittington, 1993), and changes in the well-being of the child and family (Rossi, 1992).

In addition to the concerns presented above, Usher (1993) asserts that many studies have found little or no difference in the effectiveness of family preservation services in decreasing out-of-home placement rates due to imprecise targeting of admission to family preservation programs and inconsistency in service delivery. He argues that evaluations were conducted despite awareness that these problematic issues were present. For example, evaluations of recently developed programs (Rossi, 1992) or those which are poorly managed are unlikely to reveal positive outcomes.

In light of these and other relevant issues, a number of recommendations for future research can be made. Certainly, definitive conclusions regarding the effectiveness of family preservation services await further research. Wells and Biegel (1991, 1992) have offered recommendations for future research in this area. These recommendations were based on discussions held at the 1989 National Conference on Intensive Family Preservation Services and the available research. Recommendations for future research included the following: (1) investigations to determine what portion of children approved for out-of-home placements meets the criteria to receive intensive home-based services; (2) outcome evaluations to determine the degree to which home-based services are meeting goals, i.e., the prevention of out-of-home placement and the reduction of future crises that may lead to placement; (3) longitudinal evaluations to assess the maintenance of treatment outcomes over time; (4) investigations to evaluate the impact of the ecological features of the program on implementation, functioning, and outcomes; (5) process evaluations to examine the clinical assumptions underlying treatment models and the ways in which clinicians and clients experience programs; (6) comprehensive evaluations of the functioning of children and their families at service termination; (7) investigations of service cost which take into account all services used by families during treatment and following termination; and (8) investigations to explore and examine those factors that act as

facilitators and barriers to the replication of services across various settings. More recently, a reorientation for future research in the area of family preservation services has been proposed. Wells (in press) has suggested that research move "toward the development of theoretical knowledge", that is, that the research be placed in a theoretical framework; that research studies investigate critical outcomes, both intermediate and ultimate; and that research from related fields, such as foster care, be used to determine further areas of family preservation services research.

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Table 1
Summary of the Results from Recent Studies Evaluating the Effectiveness of Family Preservation and Family Reunification Services in Preventing Out-of-Home Placement.

Authors	Percent of Children with Family at Service Termination		12 Month Follow-up		Other Frequencies of Follow-up		Sample Size
	Treatment	Control	Treatment	Control	Treatment	Control	
Haapala & Kinney (1988)[a]	–	–	87%	–	–	–	N = 678 status offenders.
Fraser, Pecora, & Haapala (1988)	>70%	–	66%WA 56% UT	–	–	–	N = 453 families at service termination; N = 263 families at 12-month follow-up.
Pecora, Fraser, & Haapala (1991,1992)	93%[b]	–	56%	15%	–	–	N = 581 children initially; N = 263 families at 12-month follow-up and N = 26 families in the control group at 12 - month follow-up.
Kinney, Haapala, & Booth (1991)	87%[c]	–	–	–	–	–	N = 58 families (101 children).
AuClaire & Schwartz (1986); Schwartz, AuClaire, & Harris (1991)	–	–	44%[d]	9%[d]	–	–	n = 55 for treatment group and n = 58 for control group.
Pearson, Masnyk, & King (1987)	90%	–	–	–	–	–	–
McDonald & Associates (1990); Yuan, et al. (1990)	–	–	–	–	No significant differences between treatment and control groups[e]		N = 304; 152 families in the treatment group and 152 families in the control group.
Feldman (1991)	92.7%	85.1%	54.2%	42.5%	–	–	n = 96 families in the treatment group and n = 87 in the control group.
Thieman & Dall (1992)	–	–	–	–	Statistically significant increase in family functioning from admission to termination.	–	N = 995 families
Berry (1992)	96%	–	88%	–	94%[f]	–	N = 367 families
Leben & Smith (1992)	79%	–	62%[g]	–	–	–	N = 109 children
Henggeler, Melton, & Smith (1992) (Rates of Re-arrest)	–	–	–	–	58% (no rearrests)[h]	38% (no rearrests)[h]	N = 84 serious juvenile offenders; n = 43 in the treatment group and n = 41 in the control group.
Henggeler, Melton, Smith, Schoenwald, & Hanley (1993) (Rates of Re-arrest)	–	–	–	–	39% (no rearrests)[i]	20% (no rearrests)[i]	N = 84 serious juvenile offenders; n = 43 in the treatment group and n = 41 in the control group.
Henggeler et al. (1993): Missouri Delinquency Project	–	–	–	–	Families in the treatment group had more supportiveness, less conflict-hostility in family relations, more cohesion and adaptability. Adolescents in the treatment group had fewer behavior problems and parents reported less symptomatology. For those who completed therapy, recidivism rates were 22% for the treatment group and 71% for the comparison group. Tx group were arrested less often and for less serious crimes!		N = 200 chronic juvenile offenders

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Table 1, continued.

Authors	Percent of Children with Family at Service Termination		12 Month Follow-up		Other Frequencies of Follow-up		Sample Size
	Treatment	Control	Treatment	Control	Treatment	Control	
Henggeler et al. (1993): Charleston, South Carolina	–	–	Treatment group had more gains in abstinence from substance abuse and delinquency and decreased institutionalization as compared to the control group.		N=20 cases adolescents with substance abuse and delinquency	–	–
Michigan Department of Social Services (1993)	–	–	24% 19%	35% 36%	7%[k] 12%[f] 5%[k] 13%[f]	15%[k] 26%[f] 12%[k] 26%[f]	N = 450 children; n = 225 in the treatment group and n = 225 in the comparison group. N = 372 children (186 pairs) from the previous sample who were referred due to abuse and/or neglect only.
Collier & Hill (1993)[l]	–	–	20% rearrested 18% reconvicted 18% reincarcerated	42% rearrested 40% reconvicted 40% reincarcerated	–	–	N = 80 families; n = 40 in treatment group and n = 40 in comparison group.
Wells & Whittington (1993)	–	–	–	–	Functioning improved between admission and discharge; no decline between discharge and follow-up. Many problems apparent at admission were resolved or improved. 59% had remained in the home in which they lived at discharge.		N = 42 families.
FAMILY REUNIFICATION SERVICES[m]							
Walton, Fraser, Lewis, Pecora, & Walton (1993)	93%	28.3%	75.4%	49%	70%	41.5%	n = 57 in the treatment group and n = 53 in the control group.
Fein & Staff (1993)	–	–	–	–	38%[n] 28%[o]	–	N = 68 children.
Woodworth, Hyde, Jordan, & Burchard (1994)	–	–	–	–	Restrictiveness of placements was less during the period following family preservation services than the period prior to out-of-home state placement.[p]		N = 30 youth.

[a] participants were status-offending youth.
[b] average placement prevention rate was 93%; 92.9% represents only "official placements" (e.g., foster care, group care, residential treatment, or hospitalization); 92.3% represents *all* placements, including placement with relatives
[c] this figure represents only "official placements".
[d] cases were followed from 12- to 16- months depending on when the case was selected. These figures represent only "official placement" rates; no significant difference was revealed when placement with relatives was considered.
[e] follow-up at 8 months
[f] follow-up at 6 months
[g] follow-up data collected at the end of the 2 year project
[h] follow-up at 59 weeks post-referral
[i] follow-up at 120 weeks post-referral
[j] 4-year follow-up
[k] 3-month follow-up
[l] adjudicated juvenile delinquents
[m] rates of reunification for youth already in out-of-home placements
[n] this figure represents family reunification rates *throughout* the first 2 years of the demonstration project.
[o] this figure represents family reunification rates *at the end* of the first 2 years.
[p] after receiving 6 months of family preservation services

Therapeutic Foster Care

According to the Select Committee on Children, Youth, and Families (1989), an estimated 500,000 children were in out-of-home settings with an approximate increase to 840,000 expected by 1995. One of the most widely utilized forms of out-of-home placement for children with serious emotional disturbances is therapeutic foster care (TFC), considered to be the least restrictive form of care among the range of residential services available to children with serious emotional disturbances (Stroul, 1989). In a review of the literature on specialized foster care programs, Webb (1988) found that nearly two-thirds of the programs described their populations as children and adolescents that have emotional or behavioral disturbances.

Therapeutic foster care is a relatively new form of treatment with a variety of models having been developed across the country during the past decade. This service approach has been defined broadly as "a service which provides treatment for troubled children within the private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions,

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thereby creating a therapeutic environment in the context of a nurturant family home" (Stroul, 1989, p. 13). A variety of terms have been used to describe therapeutic foster care, such as specialized foster family care, special foster care, treatment foster care, foster family-based treatment, individualized residential treatment, professional parenting, intensive foster care, and others. For the purposes of this paper, the generic term therapeutic foster care will be used.

Although there is great variability among models and a lack of agreement regarding terminology, most TFC programs share common features. These general characteristics include the following: children are placed with foster parents who have been carefully selected to work with children with special needs; foster parents receive preservice and/or inservice education or training to assist them in working effectively with the child; with occasional exceptions, only one child is placed in a home at one point in time; program staff have small caseloads which allow them to work in a close and intensive manner with each child and family; a support system is developed among foster care parents; foster parents receive a special stipend that is significantly higher than the rate provided to traditional foster parents; and biological families are provided with counseling, support, and other types of assistance (Meadowcroft, 1989; Stroul, 1989). TFC programs differ in such areas as treatment approach, structure, intensity, type of training and support provided, and amount of payment to foster care parents (Research and Training Center for Children's Mental Health, 1986).

A number of advantages of therapeutic foster care programs over other residential services have been noted in the literature. One advantage is the flexibility of the programs. Within this type of program, it is possible to provide services to children of varying ages and with a variety of presenting problems. Further, TFC provides a less restrictive and more natural environment for the provision of treatment; the generalization of treatment gains are enhanced because of the family environment; TFC services are highly individualized; children receive a sense of "connectedness"; and TFC is viewed more positively than other residential treatment programs. With regard to cost, therapeutic foster care programs are relatively easy and inexpensive to start. This is attributed primarily to the fact that no special facility is needed and programs can be started on a small scale with only a few staff and a

limited number of treatment homes. Additionally, the cost of therapeutic foster care is lower in comparison to other residential placement settings (Stroul, 1989; Stroul & Friedman, 1986).

Effectiveness and Outcome Research

As a means of evaluating the effectiveness of a TFC program, most studies have examined discharge data. "Successful discharge" is defined as a situation in which the child leaves the TFC program and enters a less restrictive setting, i.e., biological home, adoptive home, foster home, or independent living. Stroul (1989) presented a review of discharge data for a number of therapeutic foster home programs. Overall, the data indicated that successful discharge rates ranged from a low of 62% to a high of 89%. A more recent survey of treatment family-based foster programs in the United States and Canada was conducted by Galaway, Nutter, and Hudson (1992). Survey findings revealed that 66% of the children discharged from these programs were placed in less restrictive settings.

Although many excellent therapeutic foster care programs have been established to meet the needs of children and families, most of the available literature consists primarily of program descriptions, with few attempts to examine effectiveness (Burns & Friedman, 1990; Webb, 1988; Woolf, 1990). Despite the paucity of research, a review of the available literature, published and unpublished, on the effectiveness of TFC is presented in the following sections. For an overview of descriptive studies of the program characteristics of therapeutic foster care, please see Meadowcroft, Thomlison, and Chamberlain (in press).

People Places, which began operating in Virginia in 1973, represents one of the first therapeutic foster care programs to be established for children with serious emotional disturbances (Bryant & Snodgrass, 1992). For 1977, Witters and Snodgrass (cited in Stroul, 1989) reported that of all admissions (N = 26), 89% were discharged to less restrictive settings, while the remaining 11% were placed in institutions. Discharge data from 1981 revealed that of the children admitted (N = 45), 86% were discharged to less restrictive settings (Jones, 1990). People Places also assessed improvements in the functioning of children on various target behaviors from time of admission to discharge. For the two samples mentioned

above, greater than 75% of the target behaviors were rated by staff as significantly improved. Target behaviors were rated again at 2 months (n = 26) and 7 months (n = 25) postdischarge. An average of 80% of the target behaviors were considered to be "no problem" or "some problem, but improving" (Jones, 1990; Snodgrass & Campbell, 1981). Discharge data were collected for the 50 youth discharged from People Places during the 3-year period of 1989-1991 (Bryant & Snodgrass, 1992). The majority (79%) were discharged to a less restrictive setting. Further, 68% had attained their permanency planning goal of adoption or return to family or relatives.

The **Professional Parenting** program was developed in 1979 by the Bringing It All Back Home (BIABH) Study Center in North Carolina. This program represents a less intensive and less structured model of therapeutic foster care, in that, the treatment program is relatively unstructured and relies on the therapeutic value of the home environment and the skills of the treatment foster parents. More structured and intensive treatment services are provided if the initial program appears inadequate. Jones (1990) reported that of the 24 children discharged, 79% of the children were in less restrictive placements upon discharge. The remaining 21% were placed in more restrictive settings, such as psychiatric hospitals, detention centers, or training schools.

Pressley Ridge Youth Development Extension (PRYDE), established in 1981, is a highly structured and intensive foster family-based treatment program for troubled and troubling children and adolescents. The main feature of the PRYDE model is the philosophy of the "professional" parent as the primary "agent of treatment" rather than as a caregiver only. Hawkins, Meadowcroft, Trout, and Luster (1985) provided the results of an evaluation of the PRYDE program. During 1984 (as of September), 13 of the 16 children in the PRYDE program had successful discharges. Thus, 82% of the youth had returned to a less restrictive setting within their community following discharge. Discharge data from 1981-1987 revealed that a total of 72% of the children (N = 114) had been placed in less restrictive settings upon discharge. In terms of long-term postdischarge status, 73% remained in less restrictive settings 1-2 years following discharge (Jones, 1990).

Hawkins, Almeida, and Samet (1990) reported the preliminary findings of a comparative evaluation of the PRYDE

program and five other out-of-home placement choices. Data were gathered from the files ($N = 461$) of the referring child welfare agency. Twenty-six of the children were served in PRYDE homes, while the remaining were placed in one of the other out-of-home settings. Again, the primary variable of interest was discharge status. On average, children discharged from the PRYDE program were placed in less restrictive settings than those in the other five placement settings. Furthermore, statistically significant differences were found between the level of restrictiveness for those discharged from PRYDE and those discharged from residential treatment centers and intensive treatment units as measured by the level of restrictiveness scale developed by the authors. The average level of restrictiveness of placements following discharge also was calculated between placement settings. Children discharged from the PRYDE program tended to have equally or less restrictive subsequent placements than children discharged from the other five placement settings. However, no data were collected on the level of restrictiveness prior to entering the PRYDE program, thus it is not known if the children were comparable at admission. Follow-up data on all children discharged from a PRYDE program was gathered by phone on an annual basis. One-year follow-up data for 86% of the 110 children discharged between July 1983 and June 1987 revealed that of these children, 76% were living in less restrictive settings one year after their discharge from the treatment home. Seventy-seven percent were either in school or employed (Jones, 1990).

Kaleidoscope, Inc. is a licensed, not-for-profit child welfare agency that strives to serve the most challenging children in the state of Illinois (Kaleidoscope Program Materials, n.d.). One program component within Kaleidoscope is the Therapeutic Foster Family Homes Program. This program provides family living and specialized services on a daily basis to about 65 children and youth who would otherwise be placed in institutions. According to Stroul (1989), discharge data indicated that 62% of the children and youth served by this program were discharged to a less restrictive setting.

Studies were conducted to evaluate the effectiveness of two specialized foster care programs located at the Oregon Social Learning Center (Chamberlain & Reid, 1991; Chamberlain & Weinrott, 1990). Transitions is a specialized foster care program for children and youth with

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serious emotional disturbances; Monitor is a specialized foster care program for chronically delinquent youth. Evaluations were conducted to determine the effectiveness of these programs.

The evaluation of the **Transitions** program utilized a randomized design in which children from the state hospital were assigned to the specialized foster care program (n=10) or to other available treatment settings within their communities (n=10). Children receiving specialized foster care services spent an average of 79% of their next year in family-based settings, while those in the comparison group spent only 49% of their time in the community. For the year following placement, the amount of time that children were maintained in community settings was compared for the experimental and control groups. The mean number of days living in community placements was not reliably different for the two groups. However, not all children in the control group (n = 7) actually received a placement outside of the hospital setting; therefore, the treatment condition appeared to serve as an effective option for the population of children with serious emotional disturbances participating in this study.

In addition to an examination of discharge status, all participants in the study were assessed across a number of measures. Results of the Child Global Assessment Scale (CGAS: Shaffer et al., 1983), used to measure level of functioning during the past month, indicated that children in both groups experienced major impairment in functioning in several areas. The Parent Daily Report Checklist (PDR; Chamberlain & Reid, 1987), which measured the occurrence of problem behaviors during the previous 24-hour period, was administered at baseline, 3 months, and 7 months. A mean daily rate was calculated for the number of problem behaviors reported for each child at each of the three points in time. At baseline, both groups showed mean daily rates of over 20 reported problems per day. At 3 months, a decrease of over 50% was evident for those in the experimental group, while the control group showed no reduction in mean daily rate of problem behavior. At 7 months, the mean daily rate decreased for the control group, but not to the level of the experimental group. Although a more rapid reduction in daily problem behaviors was evident for the experimental group, no significant group-by-time interaction effect was apparent. The Behavior Symptom Inventory (BSI;

Derogatis & Spencer, 1982), a self-report inventory in which children rate their own level of functioning, was administered prior to placement and at seven months following placement. Members in the experimental group reported twice as many problems as did those in the control group at both measurement points. The Adolescent Problem Inventory (API; Gaffney & McFall, 1981) designed for youth 12 years and older and the Taxonomy of Problematic Social Situations (TOPS; Dodge, McClaskey, & Feldman, 1985) designed for children below the age of 12 were administered to assess the child's level of social competency. No significant improvement was observed for either group on these measures.

A second evaluation study was conducted to determine the effectiveness of the **Monitor Program** which provided specialized foster care services to 12- to 18-year old youths who had a history of chronic delinquency (Chamberlain, 1990; Chamberlain & Weinrott, 1990). Youth (N = 32; 16 matched cases) in the Monitor program were matched to other youth with similar characteristics and histories and who had been committed and diverted to traditional community treatment programs, such as group homes, residential treatment centers, or intensive probation. Data were gathered on the number of days incarcerated in state training schools during the one-year follow-up period prior to placement in a diversion program, number of days in treatment, and number of days incarcerated during the 2-year postdischarge period. No significant differences were found for the two groups on number of days incarcerated during the pretreatment period or average amount of days in treatment. However, a greater number of youth in the Monitor group were incarcerated less frequently and for shorter periods of time than those who received an alternative type of service. Further, a greater proportion of youth in the Monitor program (75%) completed their community programs in comparison to those in the control group (31%).

Two year follow-up data on institutionalization rates were gathered for the two groups. Over the follow-up period, a significant difference was found between the two groups. Fifty percent of the youth in the experimental group were reincarcerated at least once during the follow-up period, as compared to 94% of those receiving traditional services. Further, a significant negative correlation was found between the number of days in treatment and the number of days of

subsequent incarceration for those in the experimental group. No significant correlation was observed for those in the comparison group.

Clark, et al. (1992) reported the preliminary findings of the **Fostering Individualized Assistance Program (FIAP)** study which compared two methods (Standard Practice or SP and Individualized Support Team or IST) used to identify and meet the mental health and related service needs of foster children with behavioral and emotional disturbances. Children in the SP group received those services which typically were available within the current foster care system, while those in the IST group received individualized wraparound services as provided by a Family Specialist. Family Specialists served a number of case management functions, such as the development of an interdisciplinary team of key figures in the lives of the children; the creation of a plan for the training of key figures; the determination of the service needs of the children and their families, identification of appropriate services to meet these needs, and the delivering and/or monitoring of these services; the preparation of a service plan; the development of a crisis plan and the provision of needed training; and the review and modification of service plans as needed.

Outcome was determined through reliable and valid measures of behavioral and emotional adjustment, academic performance, foster placement status, and birth family interactions. Preliminary data (N = 97 to 102) collected at the 6-month point in the project suggested the following results: (1) based on interviews conducted with caretakers, although the difference is not significant, the number of maladaptive events in the IST group decreased, while the trend for those in the SP group was flat; (2) on the Youth Self Report Scale (YSR; Achenbach, 1991), those in the IST group reported significantly fewer aggressive behaviors and somatic complaints than those in the SP group; (03) a multivariate analysis revealed an overall statistically significant difference on the YSR in the IST group, post-intervention, which was indicative of fewer behavioral problems than the SP group; (4) a general, but not significant, trend toward fewer problems in the IST group as compared to the SP group on all subscales of the Child Behavior Checklist was revealed (CBCL; Achenbach, 1991); (5) on the Social Skills Rating System (SSRS; Gresham & Elliott, 1990), those in the IST group and their caretakers reported higher levels of cooperative behavior following the IST intervention as

compared to pre-intervention, while no such trend was observed for those in the SP group; (6) a nearly significant difference in amount of time spent in more restrictive treatment settings was apparent, with IST children spending less time than those in the comparison group; (7) a general but not significant trend toward fewer serious problem behaviors for those in the IST group as compared to those in the SP group was indicated; and (8) a reduction in the annual rate of placement changes for the IST children was observed, while the average placement change rate for the SP group remained fairly constant.

Lee, Clark, and Boyd (1994) reported the preliminary findings of the impact of the IST strategy on delinquency. Analyses involved 132 children (n = 54 in the IST group and n = 78 in the SP group) of which 15% had some juvenile justice record prior to entering foster care. Juvenile justice records were examined at three points in time: (1) before placement in foster care, (2) after placement in foster care, but before the initiation of the FIAP study, and (3) after the inception of the FIAP study. No significant differences in the percentage of children with delinquency histories or kinds of offenses were revealed between the two groups at the first point in time. At the second point in time, no significant differences were apparent between the IST and SP group. An examination of juvenile justice records at the third point in time revealed that a larger portion of the IST children (35%) experienced no arrests during the post-FIAP period as compared to those in the SP group (29%); however, the difference was not significant. For those children who had no history of delinquent behaviors either before entering foster care or during foster care, results revealed that only a small proportion of youth in both groups (12% for IST group and 18% for the SP group) experienced an arrest. This difference approached significance. For those youth who had delinquency records both before and during the FIAP project, a smaller percentage of those in the IST group (59%) had arrests as compared to 71% in the SP group; again, this difference was not significant.

Case rates, a "statistic in general use for reporting prevalence of delinquency, are defined as the number of arrests officially recorded per 1,000 youths, ages 10 through 17" (Department of Justice, National Center for Juvenile Justice cited in Lee, Clark, & Boyd, 1994, p. 308-309), were calculated as an outcome measure. Results revealed a decrease of 43% in the case rate for IST youth in comparison to

the case rate for the SP group which remained essentially the same. IST youth were only 60% as likely to be arrested during the post-FIAP period as compared to youth in the SP group.

The Mentor Program was a short-term, family-based residential treatment model developed to serve as an alternative to psychiatric hospitalization for children (Mikkelsen, Bereika, & McKenzie, 1993). The program utilized a multidisciplinary team of professionals and mentors (specially trained individuals) who worked with the child and the biological family within the home of the mentor. The program shares a number of similarities with treatment foster care; however, differences are evident. The principal difference between treatment foster care and the Mentor Program is the function of the program as the Mentor Program is designed to provide acute care on a shorter-term basis.

Outcome data for 112 consecutive admissions revealed that at discharge, 72% of the children with planned discharges were returned to their family or relatives, 17% were placed in long-term specialized foster care settings, 5% were placed in group homes, and 6% were placed in psychiatric hospitals or residential treatment centers. Three month follow-up data (N = 61 discharged children) indicated that 67.2% were living at home or with relatives, 11.5% were in foster care placements, 4.9% were in specialized foster care settings, 11.4% were in residential placements such as hospitals, RTCs, or substance abuse treatment facilities, and 5% were categorized as "other" or "unspecified".

The **Maryland Department of Human Resources** (198") examined the effectiveness of specialized foster care services by evaluating improvement in functioning at time of placement and six months after discharge. Measures of functioning revealed that almost all categories of behavior problems decreased for children receiving therapeutic foster care services, while behavior problems increased for those in the control group.

In a report of therapeutic foster care programs in the **San Francisco Bay area**, Beggs (1987) presented the following discharge data for three programs. "Future Families" in Aptos, California, reported that 78% of the youth were discharged to less restrictive settings, while 18% were placed in residential treatment settings. The San Francisco "Therapeutic Family Homes Program" reported that 80% were

discharged to less restrictive settings, while 17% were placed in residential treatment centers. The "St. Vincent's School for Boys" in San Rafael, California, reported that only 13% were discharged to more restrictive settings such as residential treatment or group homes.

Bryant, Simmens, and McKee (1989) reported discharge data for the **Missouri Division of Family Services Foster Family Treatment Program**. Data indicated that 74% were placed in less restrictive settings upon discharge from the program.

Two studies examining **specialist foster family care practices in England** have provided support for their effectiveness. Practices are based on the Swedish model of community care for adolescents which incorporates the principles of normalization, localization, voluntariness, and participation. An examination of the Kent Family Placement Project (Hazel, 1989) revealed that the program was effective in serving as an alternative to residential or custodial care for delinquent and severely troubled adolescents. In a comparison of specialist foster family care practices and residential child care practices, Colton (1990) found that overall, the special foster family care programs were found to be significantly more child-oriented than the residential placement settings on four dimensions of care: the management of daily events; children's involvement in community activities; the provision of physical amenities; and the controls and sanctions used by caregivers.

Cost-Effectiveness Research

Therapeutic foster care programs typically are the least expensive service in the range of residential services available to children with serious emotional disturbances (Stroul & Friedman, 1986). Due to the wide disparity among payments made to treatment parents and differences in methods of cost calculation, the reported costs of TFC vary significantly. An overview of the costs of various therapeutic foster care programs, which range from $35/day to $150/day, has been provided (see Stroul, 1989).

Despite this wide variation in cost, TFC compares favorably with the cost of other residential services. A survey conducted by Snodgrass and Bryant (1989) revealed that over 90% of the TFC programs reported their costs to be lower than group

homes or institutional placement settings. Other studies and reviews have documented similar cost savings. Bryant (1981) provided evidence of the cost-effectiveness of early therapeutic foster care programs. For example, the Alberta Parent Counselors Program provided therapeutic foster care services to children with emotional disturbances at half the cost of residential care, while the Massachusetts Treatment Alternative Project served children who were scheduled to enter a residential placement setting at two-thirds the cost. People Places provided treatment to children with severe disturbances at half the cost of institutional placement.

A recent comparison of the costs of TFC and other residential treatment settings in California was conducted by Beggs (1987). Again, TFC was estimated to cost less than group homes, sub-acute facilities, and acute hospitals. Hawkins, Almeida, and Samet (1990) conducted a comparison study of a foster-family-based treatment program (PRYDE) and five other out-of-home placement choices (residential treatment centers, specialized foster care settings, group homes, intensive treatment units, and parents). Results revealed that placement in the PRYDE program was less expensive, on a daily basis, than the other placement choices included in the study, with the exception of specialized foster care.

Chamberlain and Reid (1991) examined the cost of a specialized foster care program for youth who had been previously hospitalized. At the time of the study, the hospital program cost was $6,000 per month, while the cost for the experimental program (specialized foster care) was $3,000 per month. Placement in the specialized foster care program saved an average of $10,280 per case in hospitalization costs.

The Kaleidoscope Program also reported substantial cost savings with regard to their Therapeutic Foster Family Program (Kaleidoscope, Inc., n.d.). Cost of treatment in a state institution was estimated to be about $40,000 per child per year, while the cost of the Individualized Treatment Program of Kaleidoscope was $72 per child per day.

The cost of the Mentor Program (Mikkelsen, Bereika, & McKenzie, 1993) was considerably less in comparison to inpatient hospitalization. The average cost per admission to the Mentor Program was reported as $3,825, while the cost per admission for psychiatric hospitalization was $18,030.